

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

0 21363

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH				ESTIMATED		MONTH		DAY		YEAR		2b. HOUR																																																			
Bonnie		Jean		Adams						<input checked="" type="checkbox"/>		8		9		19		80		M																																																			
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD				MONTH		DAY		YEAR		2d. HOUR																																																	
Female		White		Nov. 11, 44		35						8				9		19		80		3:35 AM																																																	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH																																																											
Berwick, Pa.				U.S.A.								Prince George's County, MD.																																																											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)												12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY																																																			
Camp Springs				Andrew's Air Force Base Hospital												Secretary				U.S. Govt.																																																			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13a. STATE												13b. COUNTY												13c. CITY OR TOWN												13d. INSIDE CITY LIMITS?												13e. STREET ADDRESS											
Md.												St. Marys												Mechanicsville												as <input type="checkbox"/> NO <input checked="" type="checkbox"/>												# 2 Cox Drive																							
14. FATHER'S NAME												15. MOTHER'S MAIDEN NAME												16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)												16b. SOCIAL SECURITY NO.												17. INFORMANT												ADDRESS											
Robert												Betty												No												198-34-9043												Robert W. Adams, Sr.												Mechanicsville, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																											
PART I DEATH WAS CAUSED BY:																																																																							
IMMEDIATE CAUSE (a) Blunt injury to chest with laceration of heart																																																																							
DUE TO, OR AS A CONSEQUENCE OF																																																																							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.																																																																							
(b)																																																																							
DUE TO, OR AS A CONSEQUENCE OF																																																																							
(c)																																																																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																																																																							
19a. DATE OF OPERATION												19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?																																															
																								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																																															
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH												21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR												21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																																															
												2:42 AM 8 9 19 80												Driver of auto/fixed object impact																																															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>												21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)												21f. LOCATION																																															
												street												Rt. 5 & Auth Rd., Camp Springs, P. G., Md.																																															
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																																																																							
ACTUAL SIGNATURE Virginia L. Dolan MD												TITLE (SPECIFY) Assistant												DATE SIGNED 8/9/80																																															
EXAMINER'S NAME (TYPE OR PRINT)												ADDRESS																																																											
Virginia L. Dolan, M.D.												111 Penn Street																																																											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)												23b. DATE												23c. NAME OF CEMETERY OR CREMATORY												23d. LOCATION CITY OR TOWN																																			
Burial												8-12-80												Christ Ch. Cemetery												Chaptico St. Marys Md.																																			
24. FUNERAL DIRECTOR NAME												ADDRESS												25a. DATE REC'D. BY REGISTRAR										25b. RECEIVED BY																																					
Huntt Funeral Home,												Waldorf, Md.												AUG 15 1980																																															



BP \_\_\_\_\_  
DHMH - 17  
(VR A15 ME (5))  
15M7/76

**NOTES TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE ADVISE THE MEDICAL EXAMINER. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH		8 0 2 1 3 6 4		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST James		MIDDLE N.		LAST Adams	
3. SEX M		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 1/ 15/ 13		6. AGE (IN YEARS) (LAST BIRTHDAY) 68 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.	
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK OR MAIN SOURCE OF INCOME) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY N I H Hosp.	
13a. STATE Wash. D.C.		13b. CITY OR TOWN Washington		13c. STREET ADDRESS 616 Quebec Place		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Richard Adams		15. MOTHER'S MAIDEN NAME FIRST MIDDLE Sarah Earl		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 238-26-0185		17. INFORMANT ADDRESS Betty Adams (Dgt) 230 W Street, N. W.				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4392 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion							
ACTUAL SIGNATURE Augusto P. Rodriguez		M.D. <u>Augusto P. Rodriguez</u>		MEDICAL EXAMINER		DATE SIGNED 8-10-80	
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez		ADDRESS 5009 Rayburn Ct, Camp Springs, Md 20631		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			
23b. DATE Aug. 16, 1980		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion AME Church, Cem		23d. LOCATION Gastonia, North Carolina			
24. FUNERAL DIRECTOR NAME Montgomery Brothers F. H.		ADDRESS 719 Kennedy St, N. W.		25a. DATE REC'D. BY REGISTRAR AUG 19 1980		25b. REGISTRAR'S SIGNATURE P. E. McNeely	

Volume 25, 1992



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8021365	
1. FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) RUDOLPH JESSE AKREN				2a DATE OF DEATH MONTH DAY YEAR AUGUST 26, 1980				2b HOUR 9:05A M	
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR 3 10 1904		6 AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minnesota		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.					
10 CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Printer-Retired		12b KIND OF BUSINESS OR INDUSTRY Govt. Print Of			
13a STATE Md.				13b COUNTY Pr. Geo		13c CITY OR TOWN Upper Marlboro		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 9700 Old Marlboro Pike	
14 FATHER'S NAME FIRST MIDDLE LAST Alex				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Augusta Wittla							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b SOCIAL SECURITY NO. 216-44-9599M		17 INFORMANT ADDRESS Lillian P. Akren Same as # 13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction 410- DUE TO, OR AS A CONSEQUENCE OF (b) Severe atherosclerosis of coronary arteries DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Arteriolonephrosclerosis, Squamous cell carcinoma of tongue, Cirrhosis of liver										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (this hospital) attended the deceased from 8/13/80 to 8/26/80, that (I) (we) last saw the deceased alive on 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22c DATE SIGNED 8/27/80	
22b SIGNATURE Ravinder Singh for M.A. Nandedkar				DEGREE Pathologist ATTENDING MEDICAL STAFF PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>							
22d PHYSICIAN'S NAME (TYPE OR PRINT) Ravinder Singh, M.D. Pathologist				22e ADDRESS Doctors' Hospital of Pr. Geo. Co. 8118 Good Luck Road, Lanham, Md. 20801							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 8-29-80		23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d LOCATION CITY OR TOWN Brentwood		COUNTY Pr. Geo.		STATE Md.	
24 FUNERAL DIRECTOR NAME Beall Funeral Home				ADDRESS 9013 Annapolis Rd. Lanham, Md.				25 PREP'D BY (NAME) (ADDRESS) (PHONE) SEP 3 1980			



SEP 3 1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8021366  
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
EUGENE BADGLEY		August 17, 1980		12:06 PM	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Male	White	Feb 4 1920	60 YRS	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
New York	USA		Prince George's County MD		
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Lanham	Doctors' Hosp. of Prince Geo. Co.		Bricklayer		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md.	PG	Dist Hgts	YES <input type="checkbox"/> NO <input type="checkbox"/>	6515 Gateway Blvd.	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME		
Gerald Badgley			Mary Slavin		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR RATES)	17 INFORMANT		
Yes		W.W.11	6543 Hil-Mar Dr., Forestville, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <i>metastatic prostatic carcinoma</i>					
185- DUE TO, OR AS A CONSEQUENCE OF (b)					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from <i>7/30</i> 19 <i>81</i> , to <i>8/17</i> 19 <i>81</i> , that (i) (we) lost <i>him</i> (he) (she) (it) (we) (did) (did not) view the body after death					
22b. SIGNATURE					
22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS		
Lewis H. Dennis, M.D.			831 University Boulevard E, Silver Spring, Md. 20903		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION
Burial		8-22-80	Ft. Lincoln Cem.		CITY OR TOWN COUNTY STATE
24 FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR	
Robt E Wilhelm		4308 Suitland Rd., Suitland, Md.		AUG 25 1980	
Funeral Home					

DATE 2 2 1966



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8021367	
FOR 1. STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) ROBERT LEROY BALDWIN					2a. DATE OF DEATH MONTH DAY YEAR August 25, 1980			2b. HOUR 9:35P M			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR FEB. 2, 1921		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD					
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER		12b. KIND OF BUSINESS OR INDUSTRY VARIOUS JOBS			
13a. STATE MARYLAND					13b. COUNTY PRINCE GEO.		13c. CITY OR TOWN COLLEGE PARK		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST JAMES BALDWIN					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE UNKNOWN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT 8212 14th Ave #302 Janet Furman Hyattsville, Md 20783							
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LUNG ABSCESS AND SEPTICEMIA 1629 DUE TO, OR AS A CONSEQUENCE OF (b) BILATERAL C.V.A WITH COMMA DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): LOBOCTOMY OF UPPER LOBE OF LEFT LUNG FOR CARCINOMA in											
19a. DATE OF OPERATION NIL		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED nil				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 7-1-1980 19 to 8-25-80 19, that (I) (we) last saw the deceased alive on 8-25-1980 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE A. R. Adair				DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/26/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. ASIF S. QADRI				22e. ADDRESS 4713 - BERWYN RD, COLLEGE PK							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/29/80		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Md.					
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Maryland						25a. DATE REC'D. BY REGISTRAR AUG 28 1980		25b. REGISTRAR'S SIGNATURE [Signature]			

6021 65214



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 2 1 3 6 8	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST ENOS		MIDDLE F.		LAST BARNETT		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
								08-21-80		12:30 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		Nov. 28, 1909		70		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.					
Penna.		U.S.A.									
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY OR COUNTY, GIVE STREET AND NO.) PRINCE GEORGES GENERAL HOSP.						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired State of Maryland		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY PG		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		12. STREET ADDRESS 9594 Apt 201 Muirkirk Rd. 20811			
14. FATHER'S NAME late David H. Barnett		15. MOTHER'S MAIDEN NAME late Mary									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 176 01 6019		17. INFORMANT ADDRESS Mrs Hester Barnett 9594 Muirkirk Rd							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adrenal metastatic carcinoma of the lung 1609 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 weeks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 8-13-1980 to 8-21-1980, that (I) (we) lost saw the deceased alive on 8-20-1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE M. Baig MD.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8/21/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. BAIG MD.				22e. ADDRESS 3450 FORT MEADE RD. LAUREL, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug 23, 1980		23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland					
24. FUNERAL DIRECTOR NAME Harry H Witzke				4112 Columbia Rd Ellicott City				25a. DATE REC'D. BY REGISTRAR AUG 25 1980			

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 1 3 6 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) VIOLET E. BAUER			2a. DATE OF DEATH MONTH DAY YEAR 8/18/80			2b. HOUR 2:00 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2-8-02		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 2 YEARS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.			
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CLINTON CONVALESCENT CENTER HARWOOD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MD.		13b. COUNTY PG		13c. CITY OR TOWN OXON HILL		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9209 Allentown Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM PORCELL					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSINA DUNNINGTON				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NONE		17. INFORMANT ADDRESS DAVID BAUER 1244 VINTAGE DR. HARWOOD, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RHEUMATOID ARTHRITIS 714-0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) DIABETES, M.									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from JAN 1979, 19 79, to 8/18, 19 80; that (I) (we) saw the deceased alive on 8/18, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE P.W.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/18/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. WISOTSKY MD.			22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-21-80		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Sutcliff P.E. MD.		
24. FUNERAL DIRECTOR NAME ADDRESS Solos 6160 Oxon Hill Rd.			25a. DATE REC'D. BY REGISTRAR AUG 22 1980			25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

0895 53 2114

Item 18, 21a-22a G547 9/15/80 dad STATE OF MARYLAND  
 1- STATE REGISTRAR DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 21370

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
**ELAINE BAYNES**

2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ MONTH DAY YEAR  
**8 10 80**

2b. HOUR AM PM  
**8:38 am**

3. SEX female 4. RACE black 5. DATE OF BIRTH MONTH DAY YEAR  
**Aug. 22, 1940**

6. AGE (IN YEARS LAST BIRTHDAY) 7. IF UNDER 1 YR. MONTHS DAYS 8. IF UNDER 24 HRS. HOURS MIN  
**39**

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) **Va.** 7b. CITIZEN OF WHAT COUNTRY? **USA** 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH  
**Prince George's County MD.**

10. CITY OR TOWN OF DEATH **Cheverly** 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
**Prince George's Hospital** 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  
**Sales Clerk** 12b. KIND OF BUSINESS OR INDUSTRY  
**Giant food**

13a. STATE **Maryland** 13b. COUNTY **P.G.** 13c. CITY OR TOWN **Lanham** 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ 13e. STREET ADDRESS  
**9003 Walkerton Drive**

14. FATHER'S NAME FIRST MIDDLE LAST  
**Ruben J. Butler** 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  
**Claudia Pugh**

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) **no** 16b. SOCIAL SECURITY NO. **578-58-8242** 17. INFORMANT ADDRESS  
**Leona Lee 4230 Dix Street NorthEast**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
 PART I DEATH WAS CAUSED BY:  
 IMMEDIATE CAUSE (a) **Multiple injuries**  
 DUE TO, OR AS A CONSEQUENCE OF  
 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  
 (b) \_\_\_\_\_  
 DUE TO, OR AS A CONSEQUENCE OF  
 (c) \_\_\_\_\_

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  
**1:20 am 8/10/80** 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  
**Passehger in motorcycle/fixed object collision**

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☒ AT WORK ☐ AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) **road** 21f. LOCATION CITY OR TOWN COUNTY STATE  
**Rt. 50 & Ardmore-Ardwick Rd. Prince George, Md.**

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

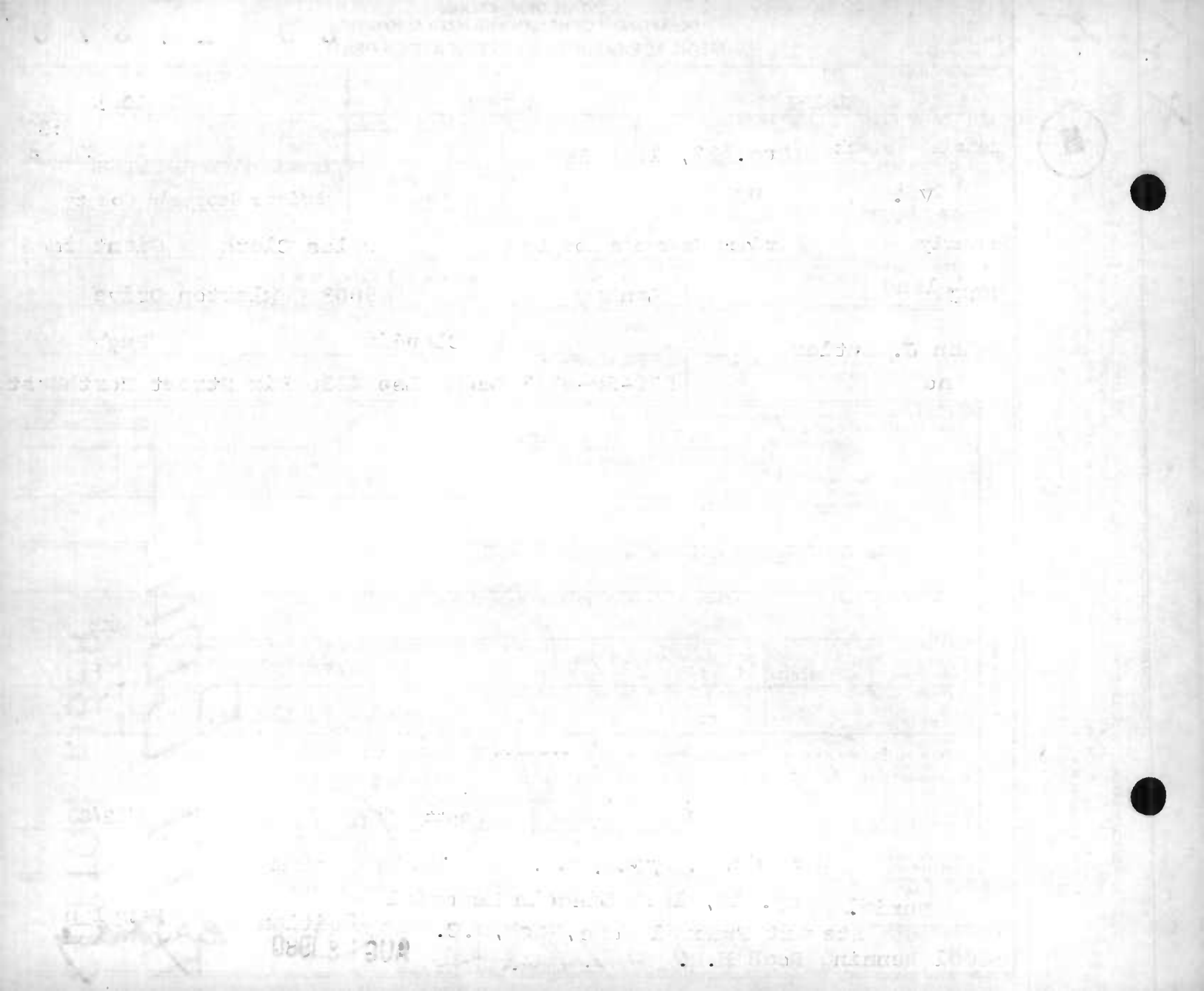
ACTUAL SIGNATURE **Thomas D. Smith** M.D. TITLE (SPECIFY)  
**Deputy Chief** MEDICAL EXAMINER DATE SIGNED **8/12/80**

EXAMINER'S NAME (TYPE OR PRINT) **Thomas D. Smith, M.D.** ADDRESS **111 Penn Street**

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) **Burial** 23b. DATE **Aug. 14, 1980** 23c. NAME OF CEMETERY OR CREMATORY **Lincoln Memorial** 23d. LOCATION CITY OR TOWN COUNTY STATE  
**Suitland Maryland**

24. FUNERAL DIRECTOR NAME **Stewart Funeral Home, Wash, D.C.** DATE REC'D. BY REGISTRAR **AUG 18 1980** REGISTRAR'S SIGNATURE **Harry H. H. H.**

2001 Benning Road N.E.



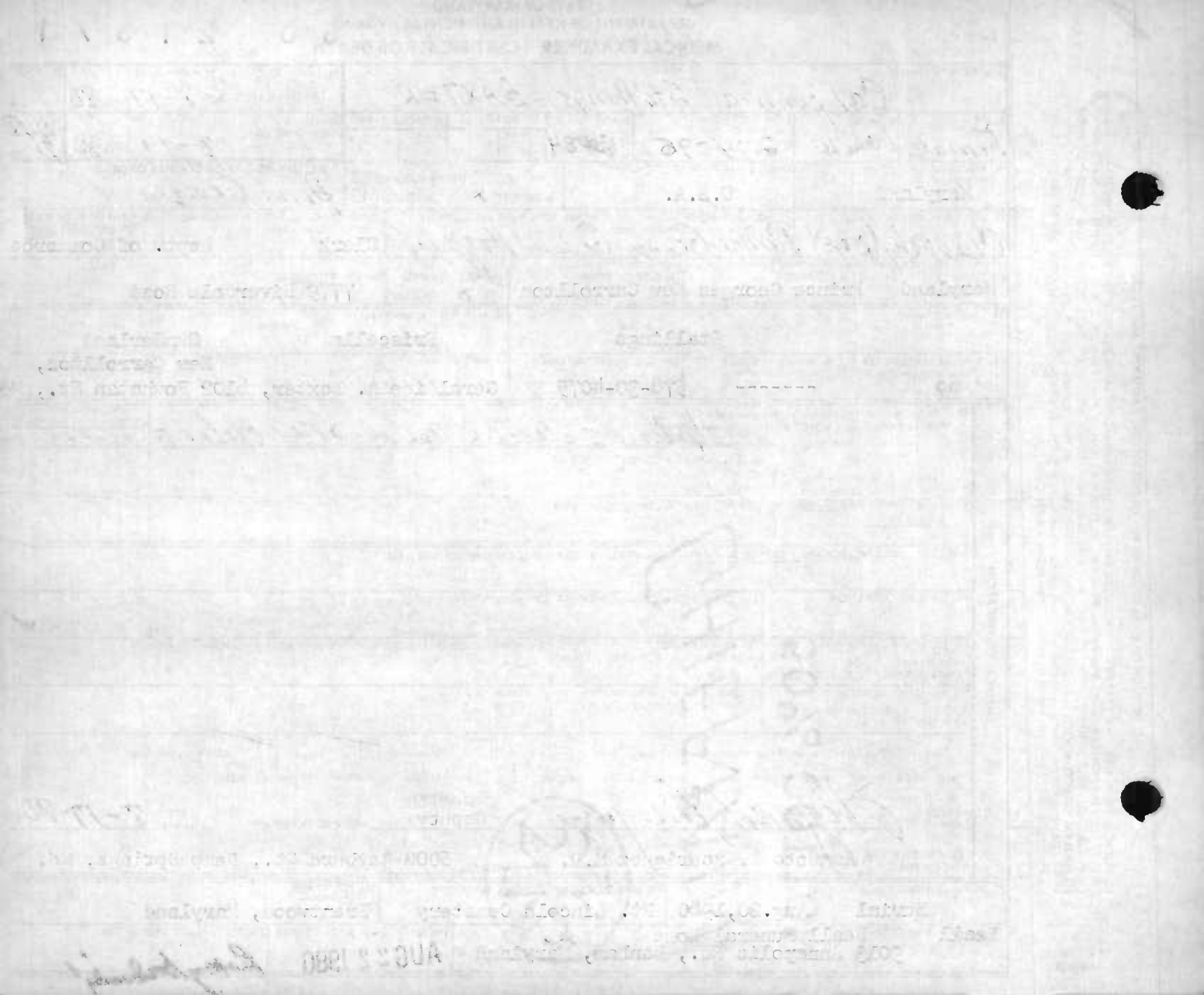


1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

0 21371

1. DECEASED NAME (TYPE OR PRINT) <i>Calpernia Stallings BAXTER</i>			2a. DATE KNOWN OF DEATH ESTI-MATED <i>8-17 1980</i>			2b. HOUR <i>4:45</i>		
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH <i>2</i> DAY <i>4</i> YEAR <i>1960</i>	6. AGE (IN YEARS) LAST BIRTHDAY <i>20</i> YEARS	IF UNDER 1 YR. MONTHS <i>0</i> DAYS <i>0</i>	IF UNDER 24 HRS. HOURS <i>0</i> MIN <i>0</i>	2c. DATE PRONOUNCED DEAD <i>8-17 1980</i>	2d. HOUR <i>4:45</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i>		
10. CITY OR TOWN OF DEATH <i>Chesedy (DCA)</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION <i>Prince George General Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Clerk</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Dept. of Commerce</i>
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Prince Georges</i>		13c. CITY OR TOWN <i>New Carrollton</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS <i>7779 Riverdale Road</i>								
14. FATHER'S NAME FIRST <i>Stallings</i> MIDDLE <i>Stallings</i> LAST <i>Stallings</i>				15. MOTHER'S MAIDEN NAME FIRST <i>Priscella</i> MIDDLE <i>Sunderland</i> LAST <i>Sunderland</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>578-30-4075</i>		17. INFORMANT <i>Geraldine A. Baxter, 8102 Powhatan St., Md</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asthenic pulmonary embolism</i> 4292 Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>		M.D. <i>Deputy</i>		TITLE (SPECIFY) <i>Deputy</i>			DATE SIGNED <i>8-17-80</i>	
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez M.D.</i>		ADDRESS <i>5009 Rayburn Ct., Camp Springs, Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Aug. 20, 1980</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Brentwood, Maryland</i>		
24. FUNERAL DIRECTOR NAME <i>Beall Funeral Home</i> <i>9013 Annapolis Rd., Lanham, Maryland</i>				25a. DATE REC'D. BY REGISTRAR <i>AUG 22 1980</i>		25b. REGISTRAR'S SIGNATURE <i>Ramph...</i>		



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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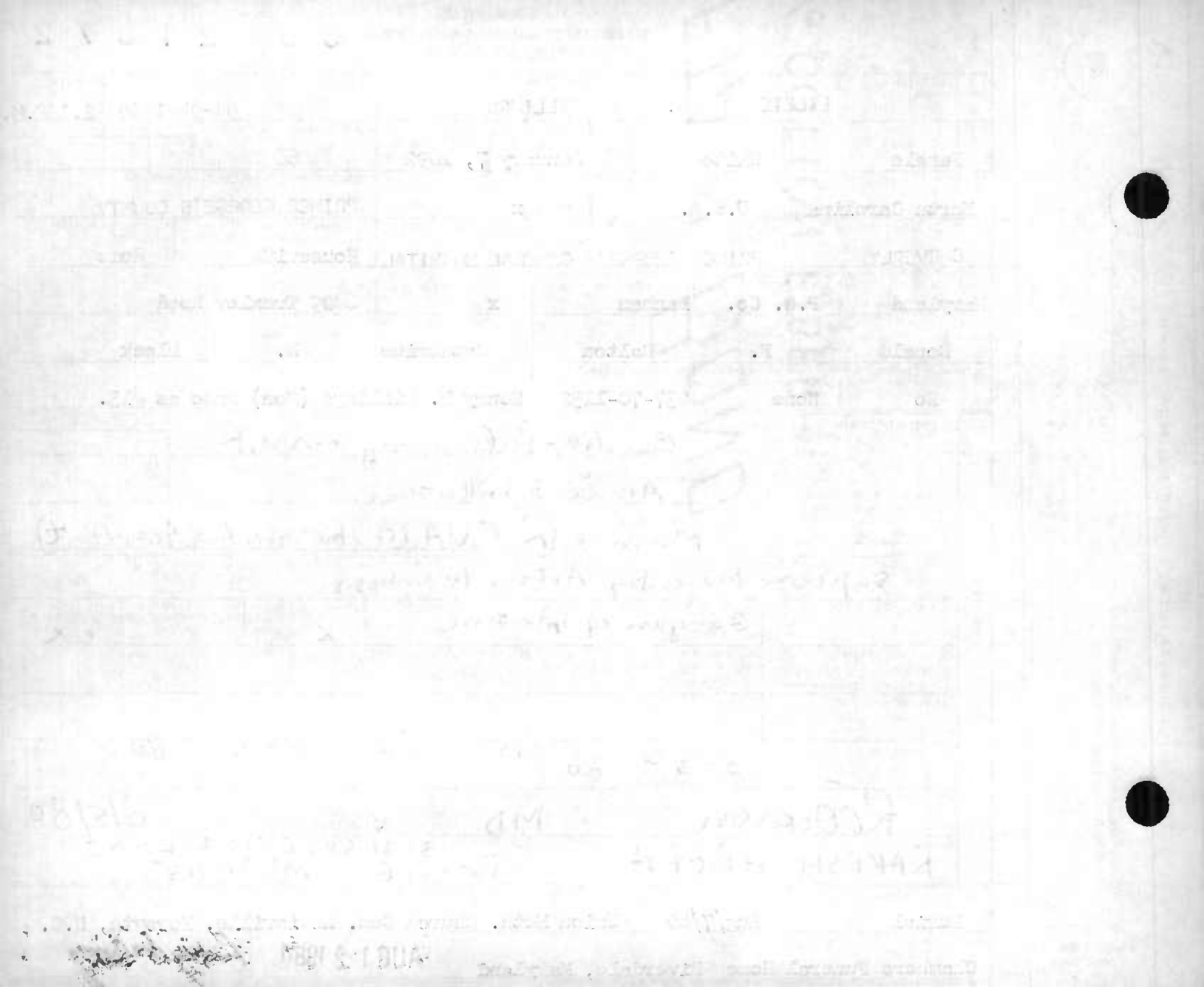
2 1 3 7 2

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>LILLIE D. BILLINGS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>08-04-1980</b>			2b. HOUR <b>2.10P.M.</b>				
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>January 7, 1892</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S COUNTY MD.</b>				
10 CITY OR TOWN OF DEATH <b>CHEVERLY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PRINCE GEORGE'S GENERAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Maryland</b>			13b. COUNTY <b>P.G. Co.</b>		13c. CITY OR TOWN <b>Lanham</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>6809 Trexler Road</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Donald F. Dalton</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine E. Black</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>None</b>		17 INFORMANT ADDRESS <b>Henry M. Billings (Son) Same as #13.</b>					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardio-Pulmonary arrest.</b> <b>436-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Atrial Fibrillation.</b> (c) <b>Massive (R) C.V.A. (Cerebrovascular Accident)</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Superior Mesenteric Artery thrombosis.</b>										
19a. DATE OF OPERATION <b>7-15-80</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Gangrene of Intestine.</b>			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>7-15-80</b> to <b>8-4-80</b> , that (I) (we) last saw the deceased alive on <b>8-3-80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.										
22b. SIGNATURE <b>R. R. R. R.</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8/5/80</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RAKESH ARORA</b>			22e. ADDRESS <b>3231 SUPERIOR LANE BOWIE MD 20715</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Aug/7/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Union Meth. Church Cem. Lewisville, Forsyth, N.C.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME <b>Chambers Funeral Home Riverdale, Maryland</b>				ADDRESS <b>Chambers Funeral Home Riverdale, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 12 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**CERTIFICATE OF DEATH**

21373

1. DECEASED-NAME (Type or print) <span style="float:right">First Middle Last</span> <div style="display: flex; justify-content: space-between;"><span>Mary</span><span>George</span><span>Black</span></div>			2a. DATE OF DEATH Month Day Year <div style="display: flex; justify-content: space-between;"><span>August</span><span>16</span><span>1980</span></div>		2b. HOUR 4:30 PM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH March 12, 1888		6. AGE (In years lost birthday) 92 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Ohio	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince Georges Md.			
10. CITY OR TOWN OF DEATH Beltsville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 11301 Emack Road	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Prince Georges	13c. CITY OR TOWN Beltsville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 11301 Emack Road		
14. FATHER'S NAME First Middle Last John C. George	15. MOTHER'S MAIDEN NAME First Middle Last UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, name (known) (If yes give war or dates of service) NO	16b. SOCIAL SECURITY NO. 265 33 4699A	17. INFORMANT Address Mary B. Scheidel Same as #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 4340 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO, OR AS A CONSEQUENCE OF (c) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2d						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Carcinoma of the colon with metastases.</u>						
19a. DATE OF OPERATION March 27, 1980	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of the colon	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>1972</u> , 19 <u>  </u> , to <u>Aug. 16</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>Aug 16</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Bennet A. Porter, Jr.</u>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <u>August 16, 1980</u>			
22d. PHYSICIAN'S NAME (Type) Bennet A. Porter, Jr.		22e. ADDRESS 9301 Coleridge Rd, Silver Spring, Md. 20901				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8/20/80	23c. NAME OF CEMETERY OR CREMATORY Oak Spring Cemetery	23d. LOCATION (City or Town) (County) (State) Cannonsburg Washington Pa			
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Maryland		25a. REC'D BY REGISTRAR DATE AUG 19 1980	25b. REGISTRAR'S SIGNATURE <u>Lucy M. Brady</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1000

STATE OF TEXAS

County of ...  
City of ...  
State of Texas

Know all men by these presents, that ...  
for and to the use of ...  
the sum of ... Dollars

to have and to hold unto the said ...  
heirs, assigns and assigns forever ...  
together with all and singular rights and appurtenances in anywise by anywise in anywise

in witness whereof, the said ...  
has hereunto set his hand and seal of office ...  
at the City of ... this ... day of ... 19...

Witness my hand and seal of office ...  
at the City of ... this ... day of ... 19...

Notary Public for the State of Texas  
My Comm. Expires ...  
My Comm. No. ...



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8021374

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MARGARET L. BLAIR</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>08-29-80</b>		2b. HOUR <b>12:03AM</b>
3. SEX <b>Female</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 1, 1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.C.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>CHEVERLY</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PRINCE GEORGE'S GENERAL HOSP.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Gov't</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN <b>Washington, D.C.</b>			13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS <b>3806 Hayes Street, N.E.</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Powell Bernhardt</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Miller</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>578 14 5584</b>		17. INFORMANT <b>6509 Midra Drive-Lanham, Md. Mrs. Gloria B. Greene-daughter</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardiac arrest****5715**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b) **Hypertension Syndrome**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Portal Cirrhosis**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:

**Diabetes mellitus; Arterial Hypertension; Head & Neck Cancer; congestive heart failure**

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>7/29</b> , 19 <b>80</b> , to <b>8/29</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>8/29</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>Leroy E Cohen MD</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Leroy E Cohen MD</b>		22e. ADDRESS <b>6261 Greenbelt Rd Suite U-16 College Park, Md.</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Sept. 2, 1980</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, Maryland</b>
24. FUNERAL DIRECTOR NAME <b>Stewart Funeral Home-4001 Benning Road, NE</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 8 1980</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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100-100000-100000

100-100000-100000

Washington, D.C. 20540

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100-100000-100000

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100-100000-100000

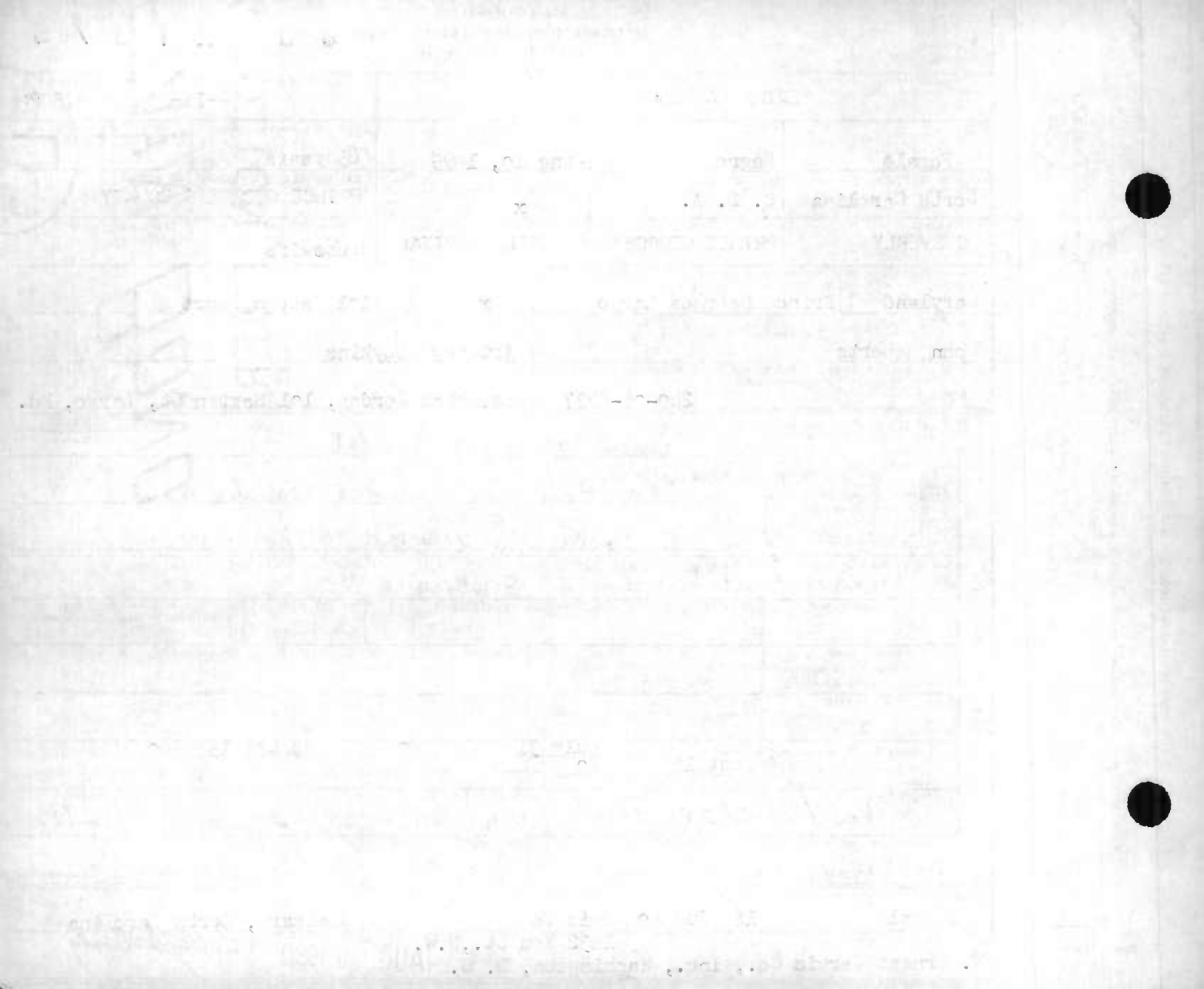
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 1 3 7 5			
1- FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BERTHA A BOONE				2a DATE OF DEATH MONTH DAY YEAR 08-15-80		2b HOUR 4:50PM	
3 SEX Female		4 RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR June 10, 1895		6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 85 years	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.	
10 CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGE'S GENERAL HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE Maryland				13b COUNTY Prince Georges Largo		13c CITY OR TOWN 101 Saxton Court	
14 FATHER'S NAME FIRST MIDDLE LAST John Roberts				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Artency Boykins			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 240-06-8937		17 INFORMANT ADDRESS Josephine Jordan, 101 Saxton Ct, Largo, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> 436- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive heart failure &amp; aspiration pneum.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebrovascular accident c (R) hemiplegia</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Urinary tract infection c Septicemia</u>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>July 31</u> , 19 <u>80</u> , to <u>August 15</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>August 15</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>R. Rustagi, M.D.</u>				DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>8/16/80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DR RAVINDER K. RUSTAGI</u>				22e. ADDRESS <u>Prince George's General Hospital, Cheverly</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 16 Aug 80		23c. NAME OF CEMETERY OR CREMATORY Ship To		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Seaboard, North Carolina</u>	
24 FUNERAL DIRECTOR NAME <u>W. Ernest Jarvis Co., Inc., Washington, D. C.</u>				25a. DATE REC'D. BY REGISTRAR <u>AUG 20 1980</u>			



**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE ADVISE THE MEDICAL EXAMINER BY TELEPHONE. PAGES 1 AND 2 OF THIS CERTIFICATE MUST BE SUBMITTED TO THE FUNERAL DIRECTOR OR TO THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL FROM THE COUNTRY.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR							
XX FRED						BOSSEMEYER		XX		AUG		17		1980		1:50							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR			
MALE		CAU		DEC 8 1896		83 YRS.		MONTHS		DAYS		HOURS		MIN		AUG		17		1980		1:50	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH											
SUPERIOR NEBRASKA				UNITED STATES								PRINCE GEORGES COUNTY MD											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
ANDREWS AFB DC				MALCROM GROW USAF MEDICAL CENTER								HATCHRYMAN											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		15th KANSAS ST									
NEBRASKA				NUCKOLLS				SUPERIOR															
14. FATHER'S NAME								15. MOTHER'S MAIDEN NAME															
FIRST MIDDLE LAST								FIRST MIDDLE LAST															
FRANK								ROSA BECKER															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS															
YES				WW1				506-01-4314				JULENE MARKS 84 WESTOVER BAFB DC 20032											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 1 DEATH WAS CAUSED BY:																							
IMMEDIATE CAUSE (a) <i>Ischemic cardiac vascular disease</i>																							
4292 DUE TO, OR AS A CONSEQUENCE OF																							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																							
(b) DUE TO, OR AS A CONSEQUENCE OF																							
(c) DUE TO, OR AS A CONSEQUENCE OF																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																							
<i>Extra medullary hematopoiesis</i>																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?							
																YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
				P.M. 19																			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET				CITY OR TOWN				COUNTY		STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE				TITLE (SPECIFY)								DATE											
<i>Augusto P. Rodriguez</i>				Deputy								8-17-80											
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																			
Augusto P. Rodriguez M.D.				5009 Rayburn Court								Camp Springs, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN				COUNTY		STATE					
Burial				19Aug1980				Evergreen Cemetery				Superior				Nuckolls		Neb.					
24. FUNERAL HOME NAME										25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE									
Robert E. Wilhelm Funeral Home Inc										AUG 25 1980				<i>Augusto P. Rodriguez</i>									
Suitland, M.d.																							



2000 2 2000



FOR										10/24/80										DEPARTMENT OF HEALTH AND MENTAL HYGIENE										REG. NO. 21377																																																	
1- STATE REGISTRAR										MEDICAL EXAMINER'S CERTIFICATE OF DEATH																																																																					
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE KNOWN OF DEATH										2b. HOUR																																																											
NICHOLAS N. BOUKNIGHT										8 24 1980										9:07 a.m.																																																											
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (IN YEARS LAST BIRTHDAY)										IF UNDER 1 YR.										IF UNDER 24 HRS.										7c. DATE PRONOUNCED DEAD										7d. HOUR									
male										negro										April 19, 1979										4										4										8 24 1980										9:07 a.m.																			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED										9. BALTIMORE CITY OR COUNTY OF DEATH																																																	
Wash. D.C.										USA										WIDOWED										Prince George's County																																																	
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)										12b. KIND OF BUSINESS OR INDUSTRY																																																	
Riverdale										Leland Memorial Hospital										N/A																																																											
13a. STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS?										13e. STREET ADDRESS																																							
Md.										PG										Adelphi										YES										1917 Fox Street																																							
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																																																																					
Nathaniel Bouknight										Carolyn Allgood																																																																					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?										16b. SOCIAL SECURITY NO.										17. INFORMANT										ADDRESS																																																	
None										N/A										Same as above										Nathaniel Bouknight (Father)																																																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																																					
PART I DEATH WAS CAUSED BY:										IMMEDIATE CAUSE (a)																																																																					
7599										Multiple congenital anomalies with complications																																																																					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:										DUE TO, OR AS A CONSEQUENCE OF																																																																					
										(b)																																																																					
										DUE TO, OR AS A CONSEQUENCE OF																																																																					
										(c)																																																																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																																																																															
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?																																																											
																				YES																																																											
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH										21b. TIME OF INJURY										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																																																											
										P.M. 19																																																																					
21d. INJURY OCCURRED WHILE NOT WHILE AT WORK										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION																																																											
																				CITY OR TOWN COUNTY STATE																																																											
22a. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from:										Natural causes, Accident, Suicide, Homicide, Undetermined manner																																																																					
ACTUAL SIGNATURE										TITLE (SPECIFY)										DATE SIGNED																																																											
Ann M. Dixon										Assistant										8-26-80																																																											
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS																																																																					
Ann M. Dixon, M.D.										111 Penn St.																																																																					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION																																																	
Burial										8/29/80										Gate of Heaven										S.S. Mont Md.																																																	
24. FUNERAL DIRECTOR										25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																																																											
Hines/Rinaldi F.H. 11800 N.H. Ave. S.S. Md.										AUG 29 1980																																																																					

(M)

WES 8 1000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 10 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST Clarence		MIDDLE Edward		LAST Boyd		2a. DATE KNOWN OF DEATH ESTI- MATED		MONTH 8	DAY 25	YEAR 19 80	2b. HOUR M 1:18A
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR Dec 25 1933		6. AGE (IN YEARS) (LAST BIRTHDAY) 46 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD		MONTH 8	DAY 26	YEAR 19 80	2d. HOUR M 1:18A
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George County MD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) GSA		12b. KIND OF BUSINESS OR INDUSTRY US Gov't			
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George General Hospital		12c. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) GSA		12b. KIND OF BUSINESS OR INDUSTRY US Gov't							
13a. STATE Maryland		13b. COUNTY Pr George		13c. CITY OR TOWN HillcrestHts		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13a. STREET ADDRESS 4012 22nd Avenue					
14. FATHER'S NAME FIRST Currie		MIDDLE F.		LAST Boyd		15. MOTHER'S MAIDEN NAME FIRST L.		MIDDLE Edith		LAST Emerson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korean		17. INFORMANT Sandra L. Boyd		ADDRESS Same as #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		Liver Cirrhosis											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion									
ACTUAL SIGNATURE JRGuard		TITLE (SPECIFY) Assistant		MEDICAL EXAMINER		DATE SIGNED 8/28/80							
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.		ADDRESS 111 Penn Street Baltimore, MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 29 Aug 1980		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE PG Md							
24. FUNERAL DIRECTOR NAME Robert E. Wilhelm		Funeral Home Inc		25a. DATE OF REGISTRATION SUITLAND, MD.									



SEP 3 1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

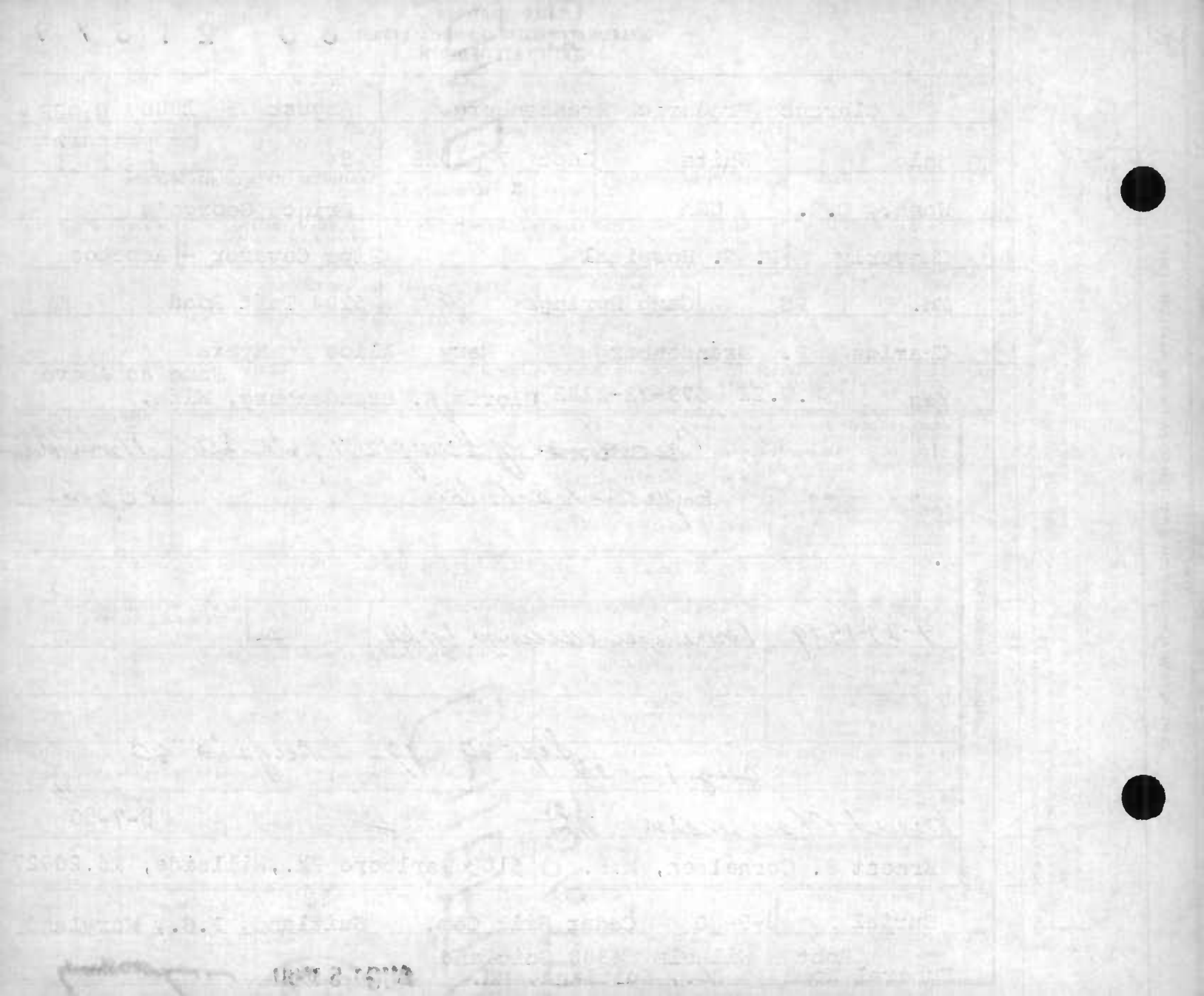
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO. 8021379						
1. DECEASED NAME (TYPE OR PRINT) <b>Clarence Frederick Brandenburg</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>August 5 1980</b>		2b. HOUR <b>8:08P M</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept 7 1925</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash., D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's MD.</b>			
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>P. G. Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Pipe Coverer -</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Asbestos</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE <b>Md.</b>		13b. COUNTY <b>PG</b>		13c. CITY OR TOWN <b>Camp Springs</b>		13e. STREET ADDRESS <b>5204 Taft Road</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles F. Brandenburg</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Alice Myers</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>W.W.11 579-22-2232</b>		17. INFORMANT ADDRESS <b>Gloria K. Brandenburg, Wife, Same as Above</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. <b>1629</b> IMMEDIATE CAUSE (a) <b>Carcinoma of lung with metastases</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Exposure to asbestos</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>11 months</b> <b>30 years</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION <b>9-24-1979</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Brunchazer carcinoma, l. l. l.</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 20, 1979</b> to <b>August 5, 1980</b> , that (I) (we) last saw the deceased alive on <b>Aug 1, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Ernest E. Cornelsen MD</b>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>8-7-80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Ernest E. Cornelsen, M.D.</b>						22e. ADDRESS <b>5103 Marlboro Pk., Hillside, Md. 20027</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8-9-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, P.G., Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Robt E Wilhelm</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG 15 1980</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
Funeral Home <b>Rd., Suitland, Md.</b>									

MEDICAL CERTIFICATION

29

BP







FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR					
Dorothy Isabelle Jessica		BRAY						8-31		19		80				M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
Female		White		1-29-08		72 YRS.						8-31		19		80				M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH								MD.	
ENGLAND		ENGLAND										Prince Georges									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY															
Cheverly		Prince Georges Hospital.		MISSIONARY																	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS													
NEW YORK		BROOKLYN				YES <input type="checkbox"/> NO <input type="checkbox"/>		306 LINCOLN ROAD													
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		FIRST		MIDDLE		LAST									
NOT		AVAILABLE				NOT		AVAILABLE													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS															
No						NEW TESTAMENT CHURCH, LANHAM, MD															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE OF DEATH		4370		Arteriosclerosis cerebro-cardio-vascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
DUE TO, OR AS A CONSEQUENCE OF																					
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.																					
DUE TO, OR AS A CONSEQUENCE OF																					
DUE TO, OR AS A CONSEQUENCE OF																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?																	
				YES <input type="checkbox"/> NO <input type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																	
		P.M. 19																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE											
22a. I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input type="checkbox"/>		and in my opinion													
death resulted from:		Natural causes <input checked="" type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		Augusto F. Rodriguez		TITLE (SPECIFY)		Deputy		MEDICAL EXAMINER		DATE SIGNED		8-31-80									
EXAMINER'S NAME (TYPE OR PRINT)		Augusto F. Rodriguez		ADDRESS		5179 Rayburn Court, Long Spring, Md.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE											
Burial		Sept 5, 1980		Woodlawn Cemetery		Baltimore		Baltimore		Maryland											
FUNERAL DIRECTOR (NAME)		254 Carroll St. N. W.		TAKOMA FUNERAL HOME.		SEP 8 1980															

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



Prince Georges Hospital.

Chesley.

254 CARROLL ST. N. W.

SEP 8 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR		8021381		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
WILLIAM Charles BRENK				AUGUST		25		1980		1:15p		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS			
MALE		WHITE		MAY 10 1907		73		YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
ILLINOIS		USA				PRINCE GEORGES						MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
ANDREWS AFB		MALCOLM GROW USAF MED CENTER		PASTRY COOK		USAF							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
MD		PR GEORGES		FORESTVILLE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2703 SHELTON PLACE					
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
JOSEPH ANTON BRENK				JENSENA JENSEN									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS							
YES		1943-1964		263-32-8778		Louise M. Brenk		2703 Shelton Place		Forestville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> <u>4275</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>9 JULY</u> 19 <u>80</u> to <u>25 AUG</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>25 AUG</u> 19 <u>80</u> , and that in <u>my</u> opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.													
22b. SIGNATURE <u>Thomas T. Yasuhara</u>				DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>25 AUG 80</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS T. YASUHARA, CAPT, USAF, MC				22e. ADDRESS MALCOLM GROW USAF MED CEN ANDREWS AFB, MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Cremation		26Aug1980		Cedar Hill Crematory		Suitland		Md					
24. FUNERAL DIRECTOR NAME Robert E. Wilhelm ADDRESS Funeral Home Inc Suitland, Md				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							
				SEP 3 1980									



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 7 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR STATE REGISTRAR		21382	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH	
Jean Elizabeth Broderick		X MONTH DAY YEAR 8 10 19 80	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)
Female	White	July 16, 1937	43 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	
Pennsylvania		U.S.A.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	
Cheverly		Prince George's General Hosp. (DOA)	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Secretary		Ins. Co.	
13a. STATE		13b. COUNTY	
Maryland		Pr. Geo.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
Frank E Paul		Betty Ginnina	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
no		n/a 577 50 9544	
17. INFORMANT		ADDRESS	
William V. Broderick Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) Traumatic injuries			
9580			
DUE TO, OR AS A CONSEQUENCE OF			
(b)			
DUE TO, OR AS A CONSEQUENCE OF			
(c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY?			
YES X NO			
21a. EXTERNAL CAUSE WAS UNDERLYING X OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY	
4:24 P.M.		8 10 19 80	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
subject laid down in front of moving train			
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK X		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
railroad tracks		Severn Rd.	
21f. LOCATION		CITY OR TOWN	
Seabrook		P.G.	
21g. LOCATION		STATE	
Md.			
22a. I certify that I took charge of the remains described above, held on Autopsy X, Inspection, Inquiry, and in my opinion death resulted from Natural causes, Accident, Suicide, Homicide, Undetermined manner.			
TITLE (SPECIFY)			
Deputy Chief			
ACTUAL SIGNATURE		DATE SIGNED	
Thomas D. Smith, M.D.		8/11/80	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS	
Thomas D. Smith, M.D.		111 Penn St. Balto., MD.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
Cremation		13 AUG 80	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Ft. Lincoln Crematory		Brentwood, Maryland	
24. FUNERAL DIRECTOR		25a. DATE BY REGISTRAR	
Beall Funeral Home		AUG 15 1980	
NAME		25b. REGISTRAR'S SIGNATURE	
9013 Annapolis Rd. Lanham, Md. 20801			

1. The first part of the report is a general description of the project and its objectives. This section should be written in a clear and concise manner, using simple language that is easy to understand. It should also include a brief history of the project and a statement of the problem being addressed.

2. The second part of the report is a detailed description of the methodology used in the study. This section should be written in a clear and concise manner, using simple language that is easy to understand. It should also include a brief history of the project and a statement of the problem being addressed.

3. The third part of the report is a detailed description of the results of the study. This section should be written in a clear and concise manner, using simple language that is easy to understand. It should also include a brief history of the project and a statement of the problem being addressed.

4. The fourth part of the report is a detailed description of the conclusions of the study. This section should be written in a clear and concise manner, using simple language that is easy to understand. It should also include a brief history of the project and a statement of the problem being addressed.

5. The fifth part of the report is a detailed description of the recommendations of the study. This section should be written in a clear and concise manner, using simple language that is easy to understand. It should also include a brief history of the project and a statement of the problem being addressed.

6. The sixth part of the report is a detailed description of the conclusions of the study. This section should be written in a clear and concise manner, using simple language that is easy to understand. It should also include a brief history of the project and a statement of the problem being addressed.

7. The seventh part of the report is a detailed description of the recommendations of the study. This section should be written in a clear and concise manner, using simple language that is easy to understand. It should also include a brief history of the project and a statement of the problem being addressed.

8. The eighth part of the report is a detailed description of the conclusions of the study. This section should be written in a clear and concise manner, using simple language that is easy to understand. It should also include a brief history of the project and a statement of the problem being addressed.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 80 21383	
1. DECEASED NAME (TYPE OR PRINT) <i>Clayton S. Brooks</i>										2a. DATE KNOWN OF DEATH ESTI-MATED <i>8-13 1980</i>										2b. HOUR <i>3:30</i>	
3. SEX <i>Male</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>8-31-31</i>		6. AGE (IN YEARS) LAST BIRTHDAY <i>49</i> YRS.		IF UNDER 1 YR. MONTHS DAYS <i>0 0</i>		IF UNDER 24 HRS. HOURS MIN. <i>0 0</i>		2c. DATE PRONOUNCED DEAD <i>8-13 1980</i>									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Washington, D.C.</i>				7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i>									
10. CITY OR TOWN OF DEATH <i>Chesley (DOR)</i>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Prince Georges General Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i>				12b. KIND OF BUSINESS OR INDUSTRY									
13a. STATE <i>Md.</i>										13b. COUNTY <i>PG</i>		13c. CITY OR TOWN <i>Lanham</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>8411 Hamlin Street</i>					
14. FATHER'S NAME FIRST MIDDLE LAST <i>William Shelly Brooks</i>										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Annie J. Caviness</i>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>yes</i>				16b. SOCIAL SECURITY NO. <i>WWII</i>		17. INFORMANT <i>Edward L. Brooks, 8419 Hamlin</i>				ADDRESS											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic renal failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>				TITLE (SPECIFY) <i>Deputy</i>				DATE SIGNED <i>8-14-80</i>													
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez M.D.</i>				ADDRESS <i>5009 Rayburn Ct., Camp Springs, Md.</i>																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>17 Aug 80</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Bethlem Cemetery</i>				23d. LOCATION CITY OR TOWN COUNTY STATE <i>Moore County, N.C.</i>											
24. FUNERAL DIRECTOR <i>Marshall's Funeral Home</i>				25a. DATE REC'D. BY REGISTRAR <i>AUG 18 1980</i>				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>													



00018000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO. 8 0 2 1 3 8 4						
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR
LOUISE A. BROWN						08-18-80			12:30PM
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	
Female		Black		Jan 21, 1911		69 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Md.		U.S.A.				PRINCE GEORGE'S MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
CHEVERLY		PRINCE GEORGE'S GENERAL HOSPITAL				Kitchen		Cook	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS
Md.			P.G.		Forestville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2706 Lakehurst Ave.
14 FATHER'S NAME FIRST MIDDLE LAST					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
Benjamin Brown					Bertha Queen				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS				
No			217-28-8019		William Nichols-Same as # 13 above				
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Brain death</u> <u>4329</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Massive intracranial hemorrhage</u> (c) <u>Uncontrolled Hypertension</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Cardiac arrhythmia</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>8/16</u> , 19 <u>80</u> , to <u>8/18</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>8/18</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>R. Rustagi, M.D.</u>							DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>8/19/80</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DR. RAVINDER K. RUSTAGI</u>					22e. ADDRESS <u>Prince George's General Hosp. Cheverly, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
			8-22-1980		HARMONY MEM. CEM.		HIGHLAND PARK, MD.		
24 FUNERAL DIRECTOR NAME ADDRESS					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
H.S. WASHINGTON & SONS 4925 BURKHOUGH AVE. W.E.					AUG 27 1980		<u>Anthony McCreedy</u>		

BP

Benjamin	Brook	Hertan	2706 Lakeland Ave.	Cook	2706 Lakeland Ave.
No.	Forestville	2	2706 Lakeland Ave.	Alcohol	2706 Lakeland Ave.
U.S.A.	2	2	2706 Lakeland Ave.	2	2706 Lakeland Ave.
2706 Lakeland Ave.	2706 Lakeland Ave.	2706 Lakeland Ave.	2706 Lakeland Ave.	2706 Lakeland Ave.	2706 Lakeland Ave.

2706-28-2019 William Nichols-Same as 13 above

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8021385	
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR	
WILLARD E. BROWN					08-21-80					2:20AM	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		Jan 1 1936		44		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
West Virginia		USA				PRINCE GEORGES MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
CHEVERLY		PRINCE GEORGES GENERAL HOSPITAL								Marbel & Tile Setter	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md.		PG		Dist Hgts		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1910 County Road			
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME						
Lloyd Brown					Mabel Haley						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS				
Yes					Korean		236-52-1445 Jean Brown, Wife, Same as Above				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Ischemic Bleeding</u>										2 days	
4560 DUE TO, OR AS A CONSEQUENCE OF											
(b) <u>Esophageal Varices</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
			HOUR A.M. MONTH DAY YEAR								
			P.M. 19								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION					
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK						STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>8-19</u> , 19 <u>80</u> , to <u>8-21</u> , 19 <u>80</u> , that <u>we</u> last saw the deceased alive on <u>8-21</u> , 19 <u>80</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, <u>we</u> (we) (did not) view the body after death.											
22b. SIGNATURE						DEGREE		22c. DATE SIGNED			
<u>Barry Epstein</u>								8-21-80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
BARRY EPSTEIN, M.D.						6201 GREENBELT RD. COLLEGE PARK, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION				
Burial			8-23-80		Wash. Natl. Cem.		Suitland, P.G., Maryland				
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
NAME <u>Welsh Funeral Home</u> ADDRESS <u>4308 Suitland Rd. Suitland, Md.</u>						AUG 26 1980					

MEDICAL CERTIFICATION

99

2402

(Date) \_\_\_\_\_



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAINED BY THE DIVISION OF VITAL RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE RETURNED TO THE DIVISION OF VITAL RECORDS WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (5))  
15M/7/77

FOR  
1- STATE REGISTRAR  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTIMATED		MONTH		DAY		YEAR		2b. HOUR	
Charles Henry		Buckey Jr.						8-18		19		80						M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
Male	White	12-4-11		68 YRS.						8-25		19		80				M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH						MD	
Maryland		USA										Anne Arundel							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Bladensburg		5455 Madison Way		Cab Driver		Ret													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Maryland		Prince George		Bladensburg		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5455 Madison Way											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
Charles H. Buckey		Florence Belle Tate																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
No		*****		577-20-4312		Chas.H.Buckey III, Temple Hills, Maryland													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
5715		IMMEDIATE CAUSE (a)		Hepatic cirrhosis															
		DUE TO, OR AS A CONSEQUENCE OF																	
		(b)		DUE TO, OR AS A CONSEQUENCE OF															
		(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED		8-25-88													
Augusto P. Rodriguez		M.D. Rodriguez		MEDICAL EXAMINER															
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE									
Augusto P. Rodriguez		5009 Rayburn Court Camp Springs		BURIAL		8/30/1980		Ft. Lincoln Cemetery		Brentwood, Maryland									
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Wade Funeral Home, Ridgely, Maryland				SEP 2 1988		R. McCreedy													

4300



TO : SAC, NEW YORK (100-111111)  
FROM : SAC, NEW YORK (100-111111)  
SUBJECT: [Illegible]

100-111111



FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

7 0 2 1 3 8 7

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI- DEATH MATED		MONTH	DAY	YEAR	2b. HOUR M
Rochelle Johanna Butler								<input checked="" type="checkbox"/>		8	22	19 80	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS (LAST BIRTHDAY))		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD		MONTH	DAY	YEAR	2d. HOUR M
Female	Black	Aug 11 1978 2		YRS.				8		22	19 80	11:06	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		USA				Prince George's County, MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Cheverly		Prince George's General Hospital		Dependent		--							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
Maryland		PG		Hyattsville		YES		8209 14th Ave #102					
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Joseph Butler				Darlene Washington									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
NO		----		Darlene Butler		Same as #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
9689 IMMEDIATE CAUSE (a) Cranio cerebral trauma													
DUE TO, OR AS A CONSEQUENCE OF													
(b)													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
?				8 22 19 80				victim of assault					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
				home				8209 14th Ave. Langley Park, P.G. MD					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE				TITLE (SPECIFY) Deputy Chief				MEDICAL EXAMINER				DATE SIGNED 8/23/80	
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS									
Thomas D. Smith, M.D.				111 Penn St. Balto., MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial				27Aug1980		Lincoln Memorial				Suitland PG Md			
24. FUNERAL DIRECTOR NAME				25. DATE REC'D. BY REGISTRAR				26. REMARKS					
Robert E. Wilhelm Funeral Home Inc				SEP 3 1980									

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR RECORDS. PAGE 4 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 10 DAYS OF DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



SEP 2 1932

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 7 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME  
(TYPE OR PRINT)

FIRST MIDDLE LAST  
*Gregory G. BYRNE*

2a. DATE KNOWN  
OF DEATH

MONTH DAY YEAR HOUR  
*08 19 80*

3. SEX

*Male*

4. RACE

*White*

5. DATE OF BIRTH

MONTH DAY YEAR  
*11-3-46*

6. AGE (IN YEARS)

*33*

IF UNDER 1 YR.

MONTHS DAYS  
*33*

IF UNDER 24 HRS.

HOURS MIN.  
*3:25 P*

2c. DATE  
PRONOUNCED  
DEAD

MONTH DAY YEAR  
*8-24 1980*

7a. BIRTHPLACE (STATE OR  
FOREIGN COUNTRY)*Florida*

7b. CITIZEN OF WHAT COUNTRY?

*U.S.A.*

8. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH

*Prince Georges*

10. CITY OR TOWN OF DEATH

*Chesley (000)*

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

*Prince Georges General Hospital*12a. USUAL OCCUPATION (TYPE OF WORK  
OR MOST OF WORKING LIFE)*Computer Programmer Unemployed*

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

*Md.*

13b. COUNTY

*P.G.*

13c. CITY OR TOWN

*College Park*

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

*7207 Rossburg Ave. Apt-B*

14. FATHER'S NAME

*Eugene*

MIDDLE

*W.*

LAST

*Byrne*

15. MOTHER'S MAIDEN NAME

*Jewell*

MIDDLE

*Dawley*

LAST

*Orlando*16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO, OR UNKNOWN)*Yes - Navy*

(IF YES, GIVE WAR OR DATES)

*Vietnam*

16b. SOCIAL SECURITY NO.

*422-64-2044*

17. INFORMANT

*Eugene W. Byrne*

ADDRESS

*1720 Lakeside Dr. Orlando, Florida*18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1 DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*9509*

Conditions, if any, which  
gave rise to immediate  
cause (a) stating the under-  
lying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒21a. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR  
CONTRIBUTING ☐ CAUSE OF DEATH21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. *8-23 1980*

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

*Self inflicted*21d. INJURY OCCURRED  
WHILE ☐ NOT WHILE ☒  
AT WORK AT WORK21e. PLACE OF INJURY (AT HOME,  
STREET, FACTORY, FARM, ETC.)*Home*21f. LOCATION  
STREET*7207 Rossburg Ave. Apt B, College Park, Md.*

22a. I certify that I took charge of the remains described above, held on

Autopsy ☐Inspection ☒Inquiry ☐

and in my opinion

death resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE*Augusto P. Rodriguez*

TITLE (SPECIFY)

*Physician*

MEDICAL EXAMINER

DATE  
SIGNED*8-24-80*EXAMINER'S NAME  
(TYPE OR PRINT)*Augusto P. Rodriguez*

ADDRESS

*5009 Rayburn Ct., Prince Georges, Md*23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)*Burial*

23b. DATE

*8-28-80*

NAME OF CEMETERY OR CREMATORY

*Oveido Cemetery*23c. LOCATION  
CITY OR TOWN*Oveido*

COUNTY

*Seminole*

STATE

*Florida*

24. FUNERAL DIRECTOR

NAME

*F. Gasch's Sons F.H. P.A. Hyattsville, Md.*

ADDRESS

25a. DATE REC'D. BY REGISTRAR

*AUG 28 1980*

25b. REGISTRAR'S SIGNATURE

*Augusto P. Rodriguez*

1000

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001 6 2400

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

4

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8021389	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BERNARD F. CADY				2a. DATE OF DEATH MONTH DAY YEAR 8/12/80				2b. HOUR 5:15 PM			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 11 18 95		6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D. C.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince Geo. MD.					
10 CITY OR TOWN OF DEATH Forestville, Md		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Regency N.N.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Express Agent		12b. KIND OF BUSINESS OR INDUSTRY Railroad			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md.		13c. COUNTY PG		13d. CITY OR TOWN Hillcrest Hgts		13e. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13f. STREET ADDRESS 1503 Fort Dupont Street			
14 FATHER'S NAME FIRST MIDDLE LAST Thomas Cady				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. 579-10-4289		17 INFORMANT Box 744 E.O.W. Va Bernard F. Cady, Son, Locust Grove,					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Arrest 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic C.V. Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immed.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a C.V.A. & Rt Hemiparesis, Chronic U.T.I., Diabetes Mellitus											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 3/2/78 to 8/12/80 that (I) (we) lost saw the deceased alive on 8/12/80 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Edwin L. Minchin, M.D.				DEGREE M.D.		22c. DATE SIGNED 8/12/80		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edwin L. Minchin			
22e. ADDRESS 6188 Oxon Hill Rd Oxon Hill Md				22f. ADDRESS 6188 Oxon Hill Rd Oxon Hill Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 8-16-80		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory Suitland, P.G. Md.		23d. LOCATION CITY OR TOWN COUNTY STATE					
24 FUNERAL DIRECTOR NAME Robt E Wilhelm		24b. ADDRESS 4308 Suitland Rd., Suitland, Md.		25a. DATE REC'D. BY REGISTRAR AUG 19 1980		25b. REGISTRAR'S SIGNATURE History McCreedy					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



3000

BP

DHMM-16 25M  
(VRA 15, 4) 1/79

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 of 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8021390	
1- FOR STATE REGISTRAR		REG. NO.									
1 DECEASED NAME (TYPE OR PRINT) NAOMI - Caldwell					2a DATE OF DEATH MONTH DAY YEAR 8-30-80			2b HOUR 2:05 P			
3 SEX Female		4 RACE ORIENTAL JAPANESE		5 DATE OF BIRTH MONTH DAY YEAR 4-22-47		6 AGE (IN YEARS LAST BIRTHDAY) 33 YRS.		7a IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7b IF UNDER 74 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) WAKKANAI, JAPAN		7b CITIZEN OF WHAT COUNTRY? JAPAN		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.					
10 CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md. Hospital Ct				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY Home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a STATE Md.		13b COUNTY P.G.		13c CITY OR TOWN New CARROLLTON		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 5327 85th AVE			
14 FATHER'S NAME FIRST MIDDLE LAST SAKAE - MAEDA					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Yoko - TAMURA						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) NONE		17 INFORMANT JAMES H. CALDWELL		ADDRESS 5327-85th AVE. #102 NEW CARROLLTON, MD. 20784					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest 7100 DUE TO, OR AS A CONSEQUENCE OF (b) Shock DUE TO, OR AS A CONSEQUENCE OF (c) Systemic Lupus Erythematosus										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION —		19b CONDITION FOR WHICH OPERATION WAS PERFORMED —				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) <del>(the hospital)</del> attended the deceased from 8-12-1980 to 8-30-1980, that (I) <del>(we)</del> last saw the deceased alive on 8-30-1980, and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) (did not) view the body after death.											
22b SIGNATURE G.S. RATH					DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED			
22d PHYSICIAN'S NAME (TYPE OR PRINT) G.S. RATH					22e ADDRESS CHARLES PROFESSIONAL BLDG WALDORF. MD. 20601						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b DATE SEPT. 2, 1980		23c NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE SUITLAND P.G. CO. MARYLAND					
24 FUNERAL DIRECTOR NAME CHAMBERS FUNERAL HOME					ADDRESS RIVERDALE, MARYLAND		25a DATE REC'D. BY REGISTRAR SEP 4 1980		25b REGISTRAR'S SIGNATURE Hester		



6891 4932

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8021391

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>OLLIE L. CAMP</b>			2a DATE OF DEATH MONTH DAY YEAR <b>8 14 80</b>		2b HOUR <b>6:50AM</b> M
3 SEX <b>Female</b>	4 RACE <b>Black</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>JAN 05 1901</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.	# UNDER 1 YEAR MONTHS DAYS # UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NORTH CAROLINA</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE</b> MD.	
10 CITY OR TOWN OF DEATH <b>LAUREL</b>	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GREATER LAUREL BEATSPILLE HOSP</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TEACHER</b>	12b KIND OF BUSINESS OR INDUSTRY <b>EDUCATION</b>	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>MD.</b>		13b COUNTY <b>HOWARD</b>	13c CITY OR TOWN <b>COLUMBIA</b>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS <b>9043 LAMBSKIN LANE</b>
14 FATHER'S NAME FIRST MIDDLE LAST <b>VORKIE G. WYN</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CHARITY G. WYN</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b SOCIAL SECURITY NO. <b>243-32-7390</b>		17 INFORMANT ADDRESS <b>DORIS C. GARDNER SOME AS 13E.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> <b>410-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Severe congestive Heart failure</b> (c) <b>Massive-Recurrent Myocardial Infarctions.</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (s) (this hospital) attended the deceased from <b>8-09-80</b> to <b>8-14-80</b> , that (s) (we) last saw the deceased alive on <b>8-14-80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (s) (we) (did) (did not) view the body after death.					
22b SIGNATURE <b>B-G. MANEJWALA</b>		DEGREE <b>MD</b>		22c DATE SIGNED <b>8-14-80</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>B-G. MANEJWALA</b>		22e ADDRESS <b>17904 George ave Olney Md 20832</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b DATE <b>AUG-16, 80</b>	23c NAME OF CEMETERY OR CREMATORY <b>ANNA JARVIS UNITED METHODIST CHURCH CEM.</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>JAYESVILLE VADKIN M.C.</b>	
24 FUNERAL DIRECTOR NAME <b>FLECK LAUREL FUNERAL HOME</b>		24b ADDRESS <b>7601 SANDY SPRING RD</b>		24c DATE RECD. BY REGISTRAR <b>AUG 15 1980</b>	24d REGISTRAR'S SIGNATURE <b>Robert McCreedy</b>





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 80 21392	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Carolyn J. Chappell</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>8-28-80</b>			2b. HOUR <b>9:30a m</b>			
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 12, 1951</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>28</b> YRS		7. IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Indiana</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County, MD.</b>					
10. CITY OR TOWN OF DEATH <b>Clinton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Southern Maryland Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk-U.S. Regulatory Comm.</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Pr. Georges Dist.</b>		13c. CITY OR TOWN <b>Hghts</b>		13d. INSIDE CITY LIMITS? <b>YES XX NO <input type="checkbox"/></b>		13e. STREET ADDRESS <b>1900 Rochell Ave.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Bruce A. Mantooth</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Idel Bennett</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>Unknown</b>		17. INFORMANT ADDRESS <b>Robert L. Chappell, same as # 13</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute tracheobronchitis &amp; pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Status epilepticus</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Several days</b> <b>10 days</b> <b>2 weeks</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Juvenile brittle diabetes mellitus, Ad. hypoparathyroidism</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>15 Aug. 1980</b> to <b>28 Aug. 1980</b> , that (I) (we) last saw the deceased alive on <b>28 Aug. 1980</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>William C. Silberman</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>28 Aug 80</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William C. Silberman MD</b>				22e. ADDRESS <b>7503 Surratts Rd. Clinton, Md. 20735</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Sept. 2,</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Forest Lawn Cemetery, Greenwood, Johnson, Ind.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME <b>Pearson's Funeral Home Falls Church, Va. 22046</b>				25a. DATE RECEIVED BY REG. <b>SEP 2 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

(M)

William C. Ellsworth MD 7503 Sutter St. Clinton, Md. 20735

SEP 1990

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 2 1 3 9 3					
FOR 1 - STATE REGISTRAR										REG. NO.					
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST TERESA V. CHIARAMONTE										2a DATE OF DEATH MONTH DAY YEAR 08 20 80				2b HOUR 11:10A <sup>PM</sup>	
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR 02 28 98		6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7 UNDER 1 YEAR MONTHS DAYS		7 UNDER 24 HRS HOURS MIN.					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.									
10 CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Center				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE 13b COUNTY 13c CITY OR TOWN New York Suffolk Shelter Island										13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS South Ferry Rd, Shelter Island Hgt			
14. FATHER'S NAME FIRST MIDDLE LAST Michael Vecchio					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Angelica Lepre										
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 059-20-1361-D		17 INFORMANT ADDRESS Michael Chiaramonte 11808 Lusby Lane Brandywine, Md. 20613											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic cardiovascular disease,</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>congestive heart failure, diabetes mellitus</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I, (a) <u>Peripheral art. disease, decubitus ulcers, pleural effusion</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE											
22a I certify that (I) (this hospital) attended the deceased from <u>8/16/80</u> , 19 <u>80</u> , to <u>8/20/80</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>8/19/80</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b SIGNATURE <u>[Signature]</u>				DEGREE				22c DATE SIGNED <u>8/20/80</u>							
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>A. GONZALES M.D.</u>				22e ADDRESS <u>Annapolis Fed Bldg, Waldorf and</u> <u>20601</u>											
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 8/23/80		23c NAME OF CEMETERY OR CREMATORY Our Lady of the Isle		23d LOCATION CITY OR TOWN COUNTY STATE Shelter Island Suffolk N.Y.									
24 FUNERAL DIRECTOR NAME Lee Funeral Home Inc.				25a DATE REC'D. BY REGISTRAR AUG 27 1980				25b REGISTRAR'S SIGNATURE <u>[Signature]</u>							
6633 Old Alex. Ferry Rd. Clinton, Maryland															

STANDARD

NEW

8/23/80

Bureau

Lee Funeral Home Inc.  
1033 Old Alex. Ter., Clinton, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 1 3 9 4 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Mamie M. Chicca</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>8 4 80</b>		2b. HOUR <b>2:35a</b> M	
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>AUGUST 21, 1901</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's</b> MD.	
10 CITY OR TOWN OF DEATH <b>Riverdale</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Leland Memorial</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>MARYLAND</b> 13b COUNTY <b>PRI. GEO.</b> 13c. CITY OR TOWN <b>HYATTSVILLE</b>				13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>4009 GALLATIN STREET</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Colaizzi</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>DiBenedictis</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b SOCIAL SECURITY NO. <b>577-36-2397</b>		17 INFORMANT <b>PAUL J. CHICCA</b>		ADDRESS <b>SAME AS 13</b> <b>SON</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4512 CONGESTIVE HEART FAILURE METASTATIC CARCINOMA</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>WHITE LEFT LEG ARTERIOCLEROTIC THROMBOSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>PAGET'S DISEASE OF THE BONE</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <b>8/13</b> 19 <b>80</b> to <b>8/15</b> 19 <b>80</b> that (I) (we) lost saw the deceased alive on <b>8/13</b> 19 <b>80</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.							
22b SIGNATURE <b>Hong Tee</b>				DEGREE <b>ATTENDING PHYSICIAN</b> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <b>8-4-80</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Hong Tee, M.D.</b>				22e ADDRESS <b>3415 Hamilton St., Hyattsville, Md. 20782</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b DATE <b>8/7/80</b>		23c NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>SILVER SPRING MONT MD.</b>	
24 FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b> ADDRESS <b>500 UNIV. BLVD. W. SILVER SPRING, MD. 20901</b>				25a DATE REC'D. BY REGISTRAR <b>AUG 8 1980</b>		25b REGISTRAR'S SIGNATURE <b>John J. McCready</b>	

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TABLE 1



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME OR TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
15M 7/77

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 80 21395	
1. DECEASED NAME (TYPE OR PRINT) <b>Clifford</b>										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <b>8</b> DAY <b>9</b> YEAR <b>1980</b>										2b. HOUR <b>M</b>	
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH <b>July</b> DAY <b>9</b> YEAR <b>1962</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>18</b> YRS.		IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>		2c. DATE PRONOUNCED DEAD MONTH <b>8</b> DAY <b>9</b> YEAR <b>1980</b>		2d. HOUR <b>8:40</b> <b>A M</b>							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S.C.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County, MD</b>									
10. CITY OR TOWN OF DEATH <b>Cheverly</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Prince George's General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Textile Worker</b>				12b. KIND OF BUSINESS OR INDUSTRY									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>S.C.</b> 13b. COUNTY <b></b>										13c. CITY OR TOWN <b>Greenwood, S.C.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS							
14. FATHER'S NAME FIRST <b>Clifton</b> MIDDLE <b></b> LAST <b></b>					15. MOTHER'S MAIDEN NAME FIRST <b>Ida</b> MIDDLE <b>Lucy</b> LAST <b>Chinn</b>																
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>					16b. SOCIAL SECURITY NO. <b>Unavailable</b>					17. INFORMANT ADDRESS <b>Clifton Chinn Sr., Greenwood, S.C.</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Blunt Injury to Head</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>6:40 8 9 1980</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>Boat being pulled by auto became unhitched striking subject</b>													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>street</b>				21f. LOCATION STREET <b>I95,</b> CITY OR TOWN <b>Landover,</b> COUNTY <b>Prince George's,</b> STATE <b>Md.</b>													
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE <b>Virginia L. Dolan</b>				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>8/9/80</b>													
EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>				ADDRESS <b>111 Penn Street</b>																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>8-17-80</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Springfield Baptist Church Cemetery</b>				23d. LOCATION CITY OR TOWN <b>Greenwood, Md.</b> COUNTY <b>Prince George's</b> STATE <b>S.C.</b>									
24. FUNERAL DIRECTOR NAME <b>N.H. Bacon</b>				ADDRESS <b>Washington, D.C.</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 11 1980</b>				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>									

DATE: 11/11/60

OFFICE: NEW YORK

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

SUBJECT: [illegible]

RE: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

11. [illegible]

12. [illegible]

13. [illegible]

14. [illegible]

15. [illegible]

16. [illegible]

17. [illegible]

18. [illegible]

19. [illegible]

20. [illegible]

21. [illegible]

22. [illegible]

23. [illegible]

24. [illegible]

25. [illegible]

26. [illegible]

27. [illegible]

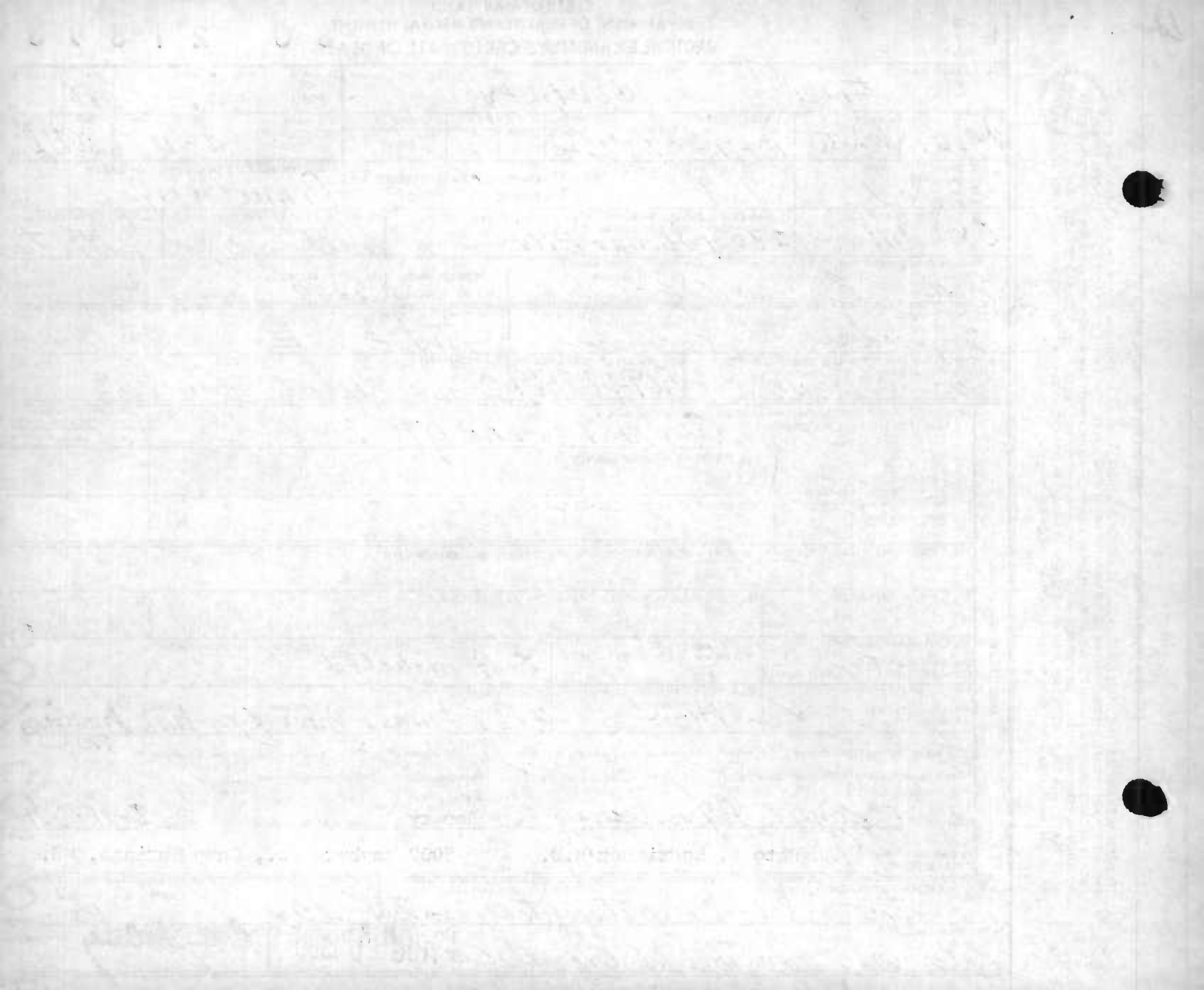
28. [illegible]

29. [illegible]

30. [illegible]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21396	
1. DECEASED NAME (TYPE OR PRINT) <i>Fred COCHRAN</i>										2a. DATE KNOWN OF DEATH ESTIMATED <i>8-11 1980</i>										2b. HOUR <i>M</i>	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>10-7-07</i>		6. AGE (IN YEARS) (LAST BIRTHDAY) <i>72 YRS.</i>		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD <i>8-11 1980</i>		2d. HOUR <i>M</i>							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Kansas</i>				7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i> MD									
10. CITY OR TOWN OF DEATH <i>Oxon Hill</i>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>2809 Lumar Drive</i>								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Self Employed</i>				12b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																					
13a. STATE <i>Md.</i>		13b. COUNTY <i>Prince Georges</i>		13c. CITY OR TOWN <i>Oxon Hill</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>2809 Lumar Dr.</i>													
14. FATHER'S NAME FIRST MIDDLE LAST <i>Commander Cochran</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>SADIE E. Taylor</i>																
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>no</i>					16b. SOCIAL SECURITY NO. <i>none</i>					17. INFORMANT <i>Emma Keplert</i>					ADDRESS <i>Same as 13</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gun shot wound of the head</i> 9534 Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>5:17 P.M. 19</i>					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>Self inflicted</i>											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Home</i>					21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>2809 Lumar Drive Oxon Hill, Prince Georges Md</i>											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>										TITLE (SPECIFY) <i>Deputy</i> M.D. MEDICAL EXAMINER										DATE SIGNED <i>8-11-80</i>	
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez M.D.</i>										ADDRESS <i>5009 Rayburn Ct., Camp Springs, Md.</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>					23b. DATE <i>8-14-80</i>					23c. NAME OF CEMETERY OR CREMATORY <i>Metropolitan Cemetery Alex</i>					23d. LOCATION CITY OR TOWN COUNTY STATE <i>VA.</i>						
24. FUNERAL DIRECTOR NAME ADDRESS <i>Kalas 6160 Oxon Hill Rd. Oxon Hill, Md</i>										25a. DATE REC'D. BY REGISTRAR <i>AUG 20 1980</i>					25b. REGISTRAR'S SIGNATURE <i>Anthony M. Brady</i>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be filed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8021397		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Evelyn Henderson COLE				2a. DATE OF DEATH MONTH DAY YEAR August 31, 1980		2b. HOUR 2:35a-AM			
3. SEX F		4. RACE N		5. DATE OF BIRTH MONTH DAY YEAR July 13 1913		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		7. UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES, MD.			
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY 42604			
13a. STATE MD		13b. COUNTY P. 6		13c. CITY OR TOWN Fairmont Heights		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 718-60th Pl.	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Evelyn Douglas					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT ADDRESS Delores Brown 7906 Dellwood Ave					
18. CAUSE OF DEATH (Enter only one cause per (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) METASTATIC ADENOCARCINOMA OF COLON 1539 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 17 mos	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <u>MARCH 19 79</u> to <u>AUGUST 30, 1980</u> , that (I) (we) lost saw the deceased alive on <u>AUGUST 30, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE James A. Brown				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8/31/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James A. Brown MD				22e. ADDRESS 625 BERKLEY RD HYATTSVILLE, MD 20782					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 9-4-80		23c. NAME OF CEMETERY OR CREMATORY Md. Nat. Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Beltsville US MD			
24. FUNERAL DIRECTOR NAME W.S. Waring & Sons 4925 ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					8 0 2 1 3 9 8 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Maxine A. Cooke</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>August 26, 1980</b>			2b. HOUR MIN <b>11:20 A M</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>FEB. 10<sup>Y</sup> 1924</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Tenn.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George</b> MD.			
10. CITY OR TOWN OF DEATH <b>Lanham</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Doctors Hospital of P.G. County</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Boards of Education</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE <b>Md.</b>		13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Cheverly</b>		13e. STREET ADDRESS <b>5837 Dewey St.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Carl L. Cansler</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Stella B. Allen</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>					16b. SOCIAL SECURITY NO. <b>231-28-0271</b>		17. INFORMANT ADDRESS <b>David E. Cooke Same as # 13</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA RECTUM WITH</b> <b>1541</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>METASTASES</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____									
19a. DATE OF OPERATION <b>1978</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cancer Rectum.</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>8-</b> 19 <b>78</b> , to <b>8-26-19-80</b> , that (I) (we) last saw the deceased alive on <b>8-26-</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <b>K. Condit</b> DEGREE <b>MD</b>					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>8/27/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>K. Joseph Mathew, MD</b>					22e. ADDRESS <b>3700-East west Highway Hyattsville</b> SH 100				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>8-29-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood, P.G., Md.</b>		
24. FUNERAL DIRECTOR NAME <b>F. Gasch's Sons, P.A. Hyattsville, Md.</b>					DATE REC'D. BY REGISTRAR <b>SEP 6 1980</b> REGISTRAR'S SIGNATURE <b>[Signature]</b>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMM-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 1 3 9 9 REG. NO.					
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>BLANCH L. COX</i>				August 30, 1980				1:20 AM	
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>1 26 05</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>75</i> YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Kansas</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince George's</i> MD.			
10. CITY OR TOWN OF DEATH <i>Clinton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Southern Maryland Hospital Center</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Nursing Aide</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Nursing</i>	
13a. STATE <i>Maryland</i>				13b. COUNTY <i>Pr. George</i>		13c. CITY OR TOWN <i>Ft. Washington</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Ernest Cox</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Unknown Unknown</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO <i>456-26-1578</i>		17. INFORMANT ADDRESS <i>1303 Fillmore Rd. Ft. Washington, Maryland</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>CVA - seizure drunk</i> <i>436-</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>deceleration</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>9-28</i> , 19 <i>79</i> , to <i>8-30</i> , 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>8-28</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <i>William Kent Furst</i>				DEGREE <i>MD</i>				22c. DATE SIGNED <i>8-30-80</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>William K. Furst</i>				22e. ADDRESS <i>9401 Indian Head Hwy. Oxon Hill, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>9/3/80</i>		23c. NAME OF CEMETERY OR CREMATORY <i>River View Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Arkansas City Cowley Kansas</i>			
24. FUNERAL DIRECTOR NAME <i>Shirley Hales</i>				24b. ADDRESS <i>6160-Old Hill</i>		25a. DATE REC'D. BY REGISTRAR <i>SEP 3 1980</i>		25b. REGISTRAR'S SIGNATURE <i>Walter Hales</i>	

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U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535



DATE: 10-10-60

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8021400			
1. FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) <b>Ralph Winton Crone</b>				2a DATE OF DEATH MONTH <b>8</b> DAY <b>29</b> YEAR <b>80</b> 2b HOUR <b>3:15 P.M.</b>			
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH <b>1</b> DAY <b>16</b> YEAR <b>11</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George</b> MD.	
10 CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hosp.</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Lounge</b>	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE <b>Dist. of Col.</b> 13c CITY OR TOWN <b>Washington</b>				13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME FIRST <b>John</b> MIDDLE <b>Crone</b> LAST <b>Crone</b>				15 MOTHER'S MAIDEN NAME FIRST <b>Lucy</b> MIDDLE <b>Stevens</b> LAST <b>Stevens</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b SOCIAL SECURITY NO <b>579-18-4001A</b>		17 INFORMANT ADDRESS	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>1629 Bronchogenic Carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>1629</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 months</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Cardiomyopathy of unknown etiology with congestive heart failure</b>							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <b>8/28</b> <b>1980</b> to <b>8/29</b> <b>1980</b> , that (I) (we) last saw the deceased alive on <b>8/28</b> <b>1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <b>Alfred Munzer</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8/29/80</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Alfred Munzer, M.D.</b>				22e ADDRESS <b>7600 Carroll Avenue Takoma Park, Md.</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>8/30/80</b>		23c. NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE	
24 FUNERAL DIRECTOR NAME <b>Anatomy Board</b> ADDRESS <b>Balto., Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 4 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



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Director of Civil  
Washington  
275-18-1001A  
John  
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Lynch  
Stevens  
London  
2701 Georgia Ave., N.W.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8021401			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST JESSIE		MIDDLE DRUMMOND		LAST CUTHILL		2a. DATE OF DEATH MONTH DAY YEAR August 20 1980		2b. HOUR 74 40A			
3. SEX female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 12, 1925		6. AGE (IN YEARS LAST BIRTHDAY) 55		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 72 HRS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Scotland		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.							
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dr Hospital of Pro Georges County						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR Vocals wagon of America			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE Md		13b. COUNTY Pro Georges		13c. CITY OR TOWN Lanham		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6914 Elbrook Road					
14. FATHER'S NAME FIRST MIDDLE LAST At Arthur Law						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Violet Livingston							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 569 76 4908		17. INFORMANT ADDRESS Douglas Cuthill Lanham, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIOGENIC SHOCK</u> 410 - DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute massive myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic cardiovascular disease</u> years										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 hours			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Dichites mellitus</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>8/4/80</u> 19 <u>80</u> to <u>8/20</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>8/20</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>P. Schissler MD</u>				DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN				22c. DATE SIGNED 8-20-80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PETER M SCHISLER MD				22e. ADDRESS 4637 EPPSON AVE ARLINGTON MD 20017									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Aug 22, 1980		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pro Georges Md.							
24. FUNERAL DIRECTOR NAME F. Gasch's Sons P A				ADDRESS Hyattsville, Md.				25a. DATE REC'D. BY REGISTRAR AUG 25 1980		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page

DHHM-16 25M  
(VRA 15, 4) 1/79

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 80 21402	
1. FOR STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT) OLA VIRGINIA DALPEE			2a DATE OF DEATH MONTH DAY YEAR AUGUST 27, 1980			2b HOUR 10:20 <sup>AM</sup>		
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR May 11, 1933		6 AGE (IN YEARS LAST BIRTHDAY) 52 YRS.		7a IF UNDER 1 YEAR MONTHS DAYS		7b IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.					
10 CITY OR TOWN OF DEATH LANHAM		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hosp. of Pr. Geo. Co.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper		12b KIND OF BUSINESS OR INDUSTRY Accounting			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland						13b COUNTY Pr. Geo.		13c CITY OR TOWN New Carrollton		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST William B Roberts						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel S Daniels					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO n/a		17 INFORMANT Joseph A. Dalpee		ADDRESS Same as # 13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Liver Failure 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (b) Liver metastases DUE TO, OR AS A CONSEQUENCE OF (c) Colon CA										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk 6 months 2 years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Hyperkalemia, Urine infection, GI bleeding											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from 8/27 19 80, to 8/27 19 80, that (I) (we) last saw the deceased alive on 8/27 19 80, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE Peter B. Sherer MD				DEGREE Covering ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED 8/27/80			
22d PHYSICIAN'S NAME (TYPE OR PRINT) PETER B. SHERER MD				22e ADDRESS 1109 Spring St. Silver Spring, Md. 20910							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE 28 AUG 80		23c NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory		23d LOCATION CITY OR TOWN COUNTY STATE Brentwood, P.G., Md					
24 FUNERAL DIRECTOR NAME Beall Funeral Home						25a DATE REC'D. BY REGISTRAR SEP 2 1980		25b REGISTRAR'S SIGNATURE [Signature]			
26 ADDRESS 9013 Annapolis Rd. Lanham, Md. 20801											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8021403 REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST McKinley H. DAVIS				August 29, 1980			
3 SEX MALE		4 RACE BLACK		5 DATE OF BIRTH APR 24, 1997		6 AGE (IN YEARS LAST BIRTHDAY) 83	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD	
10 CITY OR TOWN OF DEATH Glenn Dale		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Glenn Dale Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CONSTRUCTION WORK		12b. KIND OF BUSINESS OR INDUSTRY PVT	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE D.C. 13c. COUNTY N/A 13d. CITY OR TOWN WASHINGTON				13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST R. L. DAVIS				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANN BAXTON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO 577348469		17 INFORMANT ADDRESS ANNA HARRISON DAUGHTER 4230 RAILST			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular accident with right hemiparesis (Old) Years 438- DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis with arrhythmia DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Urinary tract infection; chronic renal disease							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from May 4, 1979, to August 29, 1980, that (X) (we) last saw the deceased alive on August 29, 1980, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) did (DEP) view the body after death.							
22b. SIGNATURE James W. Wills, M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Aug. 29, 1980	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James W. Wills, M.D.				22e. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland 20769			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE SEPT 5, 1980		23c. NAME OF CEMETERY OR CREMATORY WASHINGTON NATIONAL		23d. LOCATION CITY OR TOWN COUNTY STATE SUTTLAND, MD	
24 FUNERAL DIRECTOR NAME Albert Pope F.H. 2617 Penna				25a. DATE REC'D. BY REGISTRAR SEP 8 1980		25b. REGISTRAR'S SIGNATURE Hester McHenry	

001200



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
15M7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH		DAY		YEAR		2b. HOUR							
Roy		Andrew		Delatos Jr				8		9		19		80		M							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR			
Male		White		June 28, 1952		28		MONTHS		DAYS		HOURS		MIN.		8		9		19		80	
7a. BIRTHPLACE (STATE OR CITY AND COUNTY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH																	
Washington, DC		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Prince George's County, MD.																	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY																	
Lanham		Doctor's Hospital (DOA)		carpenter		construction																	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS															
Md		PG		Laurel		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		9028 Cherry Lane															
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST													
Roy		Andrew		Delatos		Janie		Hartless															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS																			
no		579 66 8020		Roy A. Delatos, Sr		8986 Cherry Lane																	
						Laurel, Md																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Drowning		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
79/02		DUE TO, OR AS A CONSEQUENCE OF																					
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF																			
		(c)																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?																			
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)																			
		4 8 9 19 80		Subject drowned while swimming																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE													
		pool		97th Place		Seabrook, Prince George's, Md.																	
22a. I certify that I took charge of the remains described above, held an		Autopsy <input checked="" type="checkbox"/>		Inspection <input type="checkbox"/>		Inquiry <input type="checkbox"/>		and in my opinion															
death resulted from:		Natural causes <input type="checkbox"/>		Accident <input checked="" type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		Virginia L. Dolan		M.D.		Assistant		MEDICAL EXAMINER		DATE SIGNED		8/9/80											
EXAMINER'S NAME (TYPE OR PRINT)		Virginia L. Dolan, M.D.		ADDRESS		111 Penn Street																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION																	
Burial		Aug. 12, 1980		Emmanuel Cemetery		Scaggsville, Md		COUNTY		STATE													
24. FUNERAL DIRECTOR NAME		Donaldson Funeral Home, Md		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE																	
				AUG 20 1980		Dorothy McCuskey																	

BP



June 26, 1933. 48

30. *calypso*.

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ROY ANDREW BELTZ

CMT

CONFIDENTIAL



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>ANNIE DENT</b>		2a. DATE KNOWN OF DEATH MATED <b>AUGUST 11, 1980</b>		2b. HOUR <b>8-11</b>	
3. DATE OF BIRTH MONTH DAY YEAR <b>APR 9, 1900</b>		4. AGE (IN YEARS) (LAST BIRTHDAY) <b>80 YRS.</b>		5. IF UNDER 1 YR. MONTHS DAYS	
6. IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD <b>AUGUST 11, 1980</b>		7d. HOUR <b>8-11</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Cheverly (DOA)</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION <b>Prince Georges General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>PVT</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b>		MD	
13a. STATE <b>MD</b>		13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>OXON HILL</b>	
13d. INSIDE CITY LIMITS? <b>YES</b> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1305 PISCATAWAY RD</b>			
14. FATHER'S NAME <b>JOHNNY MARSHALL</b>		15. MOTHER'S MAIDEN NAME <b>LILLIAN JACKSON</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>577 84 4299</b>		17. INFORMANT <b>WILLIAM DENT</b> ADDRESS <b>NEPHEW 1615 C STREET S.E.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4029</b> IMMEDIATE CAUSE (a) <b>Hypertensive cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <b>Diabetes mellitus</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b>		TITLE (SPECIFY) <b>Deputy</b>		DATE SIGNED <b>8-11-80</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Augusto P. Rodriguez M.D.</b>		ADDRESS <b>5009 Rayburn Ct., Camp Springs, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>AUG 15, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LINCOLN MEMORIAL</b>	
23d. LOCATION CITY OR TOWN <b>SUITLAND, MD</b>		COUNTY		STATE	
24. FUNERAL DIRECTOR <b>ALEXANDER S. POPE</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 11, 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Harry Maloney</b>	

1900, 80

PVT

HOUSEWIFE

1305 PISCATAWAY RD

XXX

OXON HILL

LILLIAN JACKSON

WILLIAM DENT

WILLIAM DENT

277 84 1522

APR 1 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8021406			
1. FOR STATE REGISTRAR		REG. NO.											
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Allan		W.		Dickson				8/12/80					M
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7a UNDER 1 YEAR		7b UNDER 24 HRS			
M		White		MONTH DAY YEAR 4 21 00		80		MONTHS DAYS		HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH							
Canada		U.S.A.				Prince Georges						MD	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OR WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY							
Clinton		5705 Alan Drive		Retired		D.C. Govern-ment							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS			
Maryland		Pr. Geo.		Clinton		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		5705 Alan Drive					
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST		FIRST MIDDLE LAST											
William James Dickson		Jane Mercer											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS							
No		None		066-12-23734		Amelia P. Dickson Same as #13							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		410 -		DUE TO, OR AS A CONSEQUENCE OF		Acute Myocardial Infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		1 hour			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		(b)		DUE TO, OR AS A CONSEQUENCE OF		Arteriosclerotic Cardiovascular Disease		10 years					
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		Carcinoma of Colon											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
7-28-80		Intestinal Obstruction		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE									
22a I certify that (I) (this hospital) attended the deceased from 11/17/1973, to 8/12/1980, that (I) (we) last saw the deceased alive on 8/12/1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED		8/12/80			
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS											
Thomas F. Cleary, M.D.		9131 Piscataway Rd., Clinton, Md.											
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE							
Burial		8/15/80		Epiphany Ch. Cemetery		Forrestville P.G. Md.							
24 FUNERAL DIRECTOR NAME		24b ADDRESS		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR SIGNATURE							
Lee Funeral Home Inc.		6633 Old Alexander Ferry Road Clinton Md.		AUG 15 1980									

—Governor —

W001 6 1204

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST Gregory			MIDDLE Diggs			LAST			2a. DATE KNOWN OF DEATH ESTI- MATED			MONTH 8			DAY 17			YEAR 1980			2b. HOUR M 11:08		
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR July 7, 1953		6. AGE (IN YEARS LAST BIRTHDAY) 27 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD			MONTH 8			DAY 17			YEAR 1980			2d. HOUR M 11:08		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD														
10. CITY OR TOWN OF DEATH Cheverly				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic				12b. KIND OF BUSINESS OR INDUSTRY Metro										
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																										
13a. STATE Md.				13b. COUNTY P.G.				13c. CITY OR TOWN Cap. Hgts.				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 1510 Brooke Rd.										
14. FATHER'S NAME FIRST MIDDLE LAST Charles Diggs						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca Brooks																				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No						16b. SOCIAL SECURITY NO. Unknown						17. INFORMANT ADDRESS Charles Diggs-Same as # 13 above														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cranio cerebral injuries</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																										
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10:18x 8 17 19 80						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) driver in motorcycle/auto impact														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street						21f. LOCATION STREET CITY OR TOWN COUNTY East-West Hwy & Toledo Terrace, Hyattsville, P.G., MD.														
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																										
ACTUAL SIGNATURE <i>Thomas D. Smith</i>						TITLE (SPECIFY) M.D. Deputy Chief						DATE SIGNED 8/18/80														
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.						ADDRESS 111 Penn St. Balto., MD.																				
23a. (BURIAL) CREMATION/REMOVAL (TICK ONE)						23b. DATE 8-21-1980						23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEM.						23d. LOCATION CITY OR TOWN COUNTY STATE BLADENSBURG P.G., MD.								
24. FUNERAL DIRECTOR NAME H. S. WASHINGTON - SONS												ADDRESS 4925 BUXROUCHS AVE. N.E.														
25a. DATE REC'D. BY REGISTRAR												25b. REGISTRAR'S SIGNATURE <i>Patrick McCready</i>														

AUG 27 1980



July 7, 1953

U.S.A.

W.

Left

Atlantic

1910 1900 1900

Cap. H. H.

1.0.

1.0.

Rebecca H. H.

1.0.

1.0.

Charles H. H. as \* 19 above

Unknown

1.0.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH		DAY		YEAR		2b. HOUR	
Marcus Redding Dillard								8 8 1980								M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male	Black	2 11 1958		22						8 8 1980						2:30	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
Maryland		✓						Prince George's County, MD									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Cheverly		Prince George's General Hospital (DOA)		Food Service													
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADDRESS)																	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
MD		PG		Seat Pleasant		YES <input type="checkbox"/> NO <input type="checkbox"/>		128 East Mill Avenue									
14. FATHER'S NAME		MIDDLE		15. MOTHER'S MAIDEN NAME		MIDDLE											
Gerald		M		Dillard		Beatrice		Williams									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No		220-70-6443		Gerald Dillard		128 East Mill Ave											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																	
PART I DEATH WAS CAUSED BY: Multiple Visceral & Skeletal Injuries																	
IMMEDIATE CAUSE (a) 8147																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.																	
(b) DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?															
20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
1:09 PM 8 8 1980				Pedestrian struck by auto													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
		street		Balto. Washington Parkway, Greenbelt, P. G., Md.													
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																	
death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE		Virginia L. Dolan		TITLE (SPECIFY) Assistant		MEDICAL EXAMINER		DATE SIGNED 8/8/80									
EXAMINER'S NAME (TYPE OR PRINT)		Virginia L. Dolan, M.D.		ADDRESS		111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION COUNTY STATE											
Burial		Aug. 13, 80		Fort Lincoln Cem.		Brentwood, MD											
24. FUNERAL DIRECTOR		ADDRESS		DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Stewart Funeral Home		4001 Benning Rd.		N.E.		AUG 18 1980											



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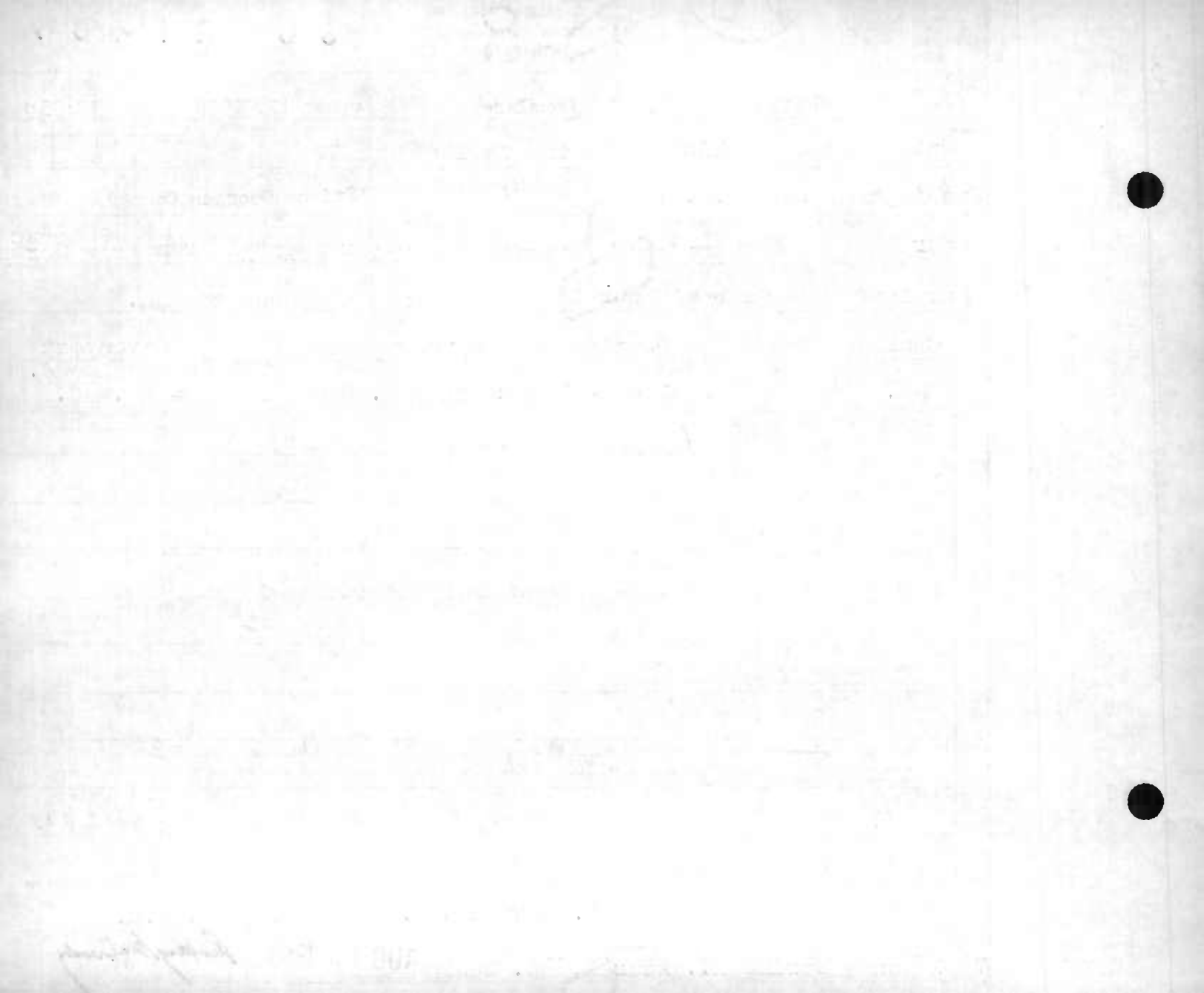
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1 DECEASED NAME (TYPE OR PRINT) <b>Charles E. Donaldson</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>August 17, 1980</b>					2b. HOUR <b>10:05 p.m.</b>
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>June 14, 1908</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges County MD.</b>				
10 CITY OR TOWN OF DEATH <b>Laurel</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Greater Laurel Beltsville Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ornamental Iron Worker</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Potomac Iron Works</b>		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY <b>Maryland Anne Arundel</b>		13c CITY OR TOWN <b>Laurel</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS <b>456 Henryton So.</b>				
14 FATHER'S NAME FIRST MIDDLE LAST <b>Charles Donaldson</b>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Agnes Davenport</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No.</b>		16b SOCIAL SECURITY NO. <b>579-05-5741</b>		17 INFORMANT <b>30727 Greenvale Rd. Charles M. Donaldson Balto. Md.</b>						
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Ventricular Arrhythmia</b> <b>5335</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Perforated peptic ulcer, esophageal carcinoma</b>										
19a DATE OF OPERATION <b>8-16-80</b>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Perforated ulcer</b>				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>L</b>						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (I) (the hospital) attended the deceased from <b>May</b> 19 <b>80</b> , to <b>Aug</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>Aug 17</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.										
22b SIGNATURE <b>Pamela Mulshine</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED <b>8/18/80</b>		
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>PAMELA MULSHINE</b>				22e ADDRESS <b>321 PRINCE GEORGE LAUREL</b>						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>8/20/80</b>		23c NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cem.</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>				
24 FUNERAL DIRECTOR <b>FLECK LAUREL FUNERAL HOME, INC.</b>				25a DATE REC'D. BY REGISTRAR <b>AUG 19 1980</b>		25b REGISTRAR'S SIGNATURE <b>Robert McHenry</b>				
7601 Sandy Spring Rd. Laurel, Md. 20810										

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8021410			
1. FOR STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR			
HELENA B. DORR					08-26-80					350 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		White		Feb. 12, 1907		73		MONTHS DAYS		HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
New York		U.S.A.				Prince Georges MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Largo		Manor Care Nursing Home				Retired			School Teacher				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Md.		P.G.		Camp Springs		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		6905 Bearkshire Drive					
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME								
John Shea					Helen Corrigan								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
No				None		405-22-1234 Helen Page Same as #13							
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a)										Cardiac arrest			
DUE TO, OR AS A CONSEQUENCE OF										Unknown			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										Arteriosclerosis, generalized			
DUE TO, OR AS A CONSEQUENCE OF										Unknown			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										Fracture, hip, old; Chronic brain syndrome			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
				HOUR A.M. MONTH DAY YEAR									
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION							
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK						STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from 7/14, 1980, to 8/26, 1980, that (1) (we) last saw the deceased alive on Aug. 21, 1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) (did) (did not) view the body after death.										22b. SIGNATURE		22c. DATE SIGNED	
Julius Kauffman, M.D.										8/26/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS								
JULIUS KAUFFMAN, M.D.					6501 LANDOVER RD CHEVERLY, MD.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			23e. STATE		
Burial			8/30/80		Ashland Cemetery			Ashland Boyd Ky.					
24. FUNERAL DIRECTOR NAME						25. DATE REC'D. BY REGISTRAR			25b. SIGNATURE				
Lee Funeral Home Inc.						SEP 4 1980							
6633 Old Alexander Ferry Road Clinton Md.													

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1. The first part of the document is a list of names and dates, which appears to be a record of some kind. The names are written in a cursive script, and the dates are in a more formal, printed style. The list is organized into two columns, with names on the left and dates on the right.

1. The first part of the document is a list of names and titles, including "The Hon. Mr. Justice" and "The Hon. Mr. Justice".

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*In situ*

08/05/80

Lee Ferry, Inc.

11-10-68

1954 255



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8021411		
1. FOR STATE REGISTRAR					REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) <b>AMY</b>					MIDDLE <b>DOUGLAS</b>					2a. DATE OF DEATH MONTH <b>08</b> DAY <b>01</b> YEAR <b>80</b>		2b. HOUR <b>2:30PM</b>
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH <b>8/22/1903</b> YEAR		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b>		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>DC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES</b> MD.						
10. CITY OR TOWN OF DEATH <b>CHEVERLY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN STATE, GIVE STREET ADDRESS) <b>PRINCE GEORGES GENERAL HOSP.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>House Wife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>				
13a. STATE <b>Glennd MD</b>					13b. COUNTY <b>Pinc Geor</b>		13c. CITY OR TOWN <b>Pince Geor</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4900 Glenndale Maryland</b>	
14. FATHER'S NAME FIRST <b>Robert</b> MIDDLE <b>Coleman</b> LAST <b></b>					15. MOTHER'S MAIDEN NAME FIRST <b>Carrie</b> MIDDLE <b>Fisher</b> LAST <b></b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>577 0542</b>		17. INFORMANT ADDRESS <b>38. Carl Netter Son, 4900 Glendale MI</b>							
18. CAUSE OF DEATH (Enter only one cause and line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>410-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Arteriosclerosis</b> (c) <b>Diabetes Mellitus</b> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROPRIATE INTERVAL BETWEEN CAUSE AND DEATH <b>2 wks</b> <b>10 yr</b> <b>15 yr</b>												
PART 2 - OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <b>Diabetes Mellitus</b>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>8/1/80</b> 19 <b>80</b> to <b>8/1/80</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>8/1/80</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death												
22b. SIGNATURE <b>Dr. Henry C. A. Rose Jr. M.D.</b>						DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>8/8/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wash, National</b>			23d. LOCATION CITY OR TOWN <b>Suitland Maryland</b> COUNTY STATE				
24. FUNERAL DIRECTOR NAME <b>Dudley S. Fun Home</b>						25a. DATE REC'D. BY REG. CLERK <b>AUG 14 1980</b>			25b. INITIALS OF REGISTRAR <b>R. J. H. H.</b>			

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11-11-11

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*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page.]*

11-11-11

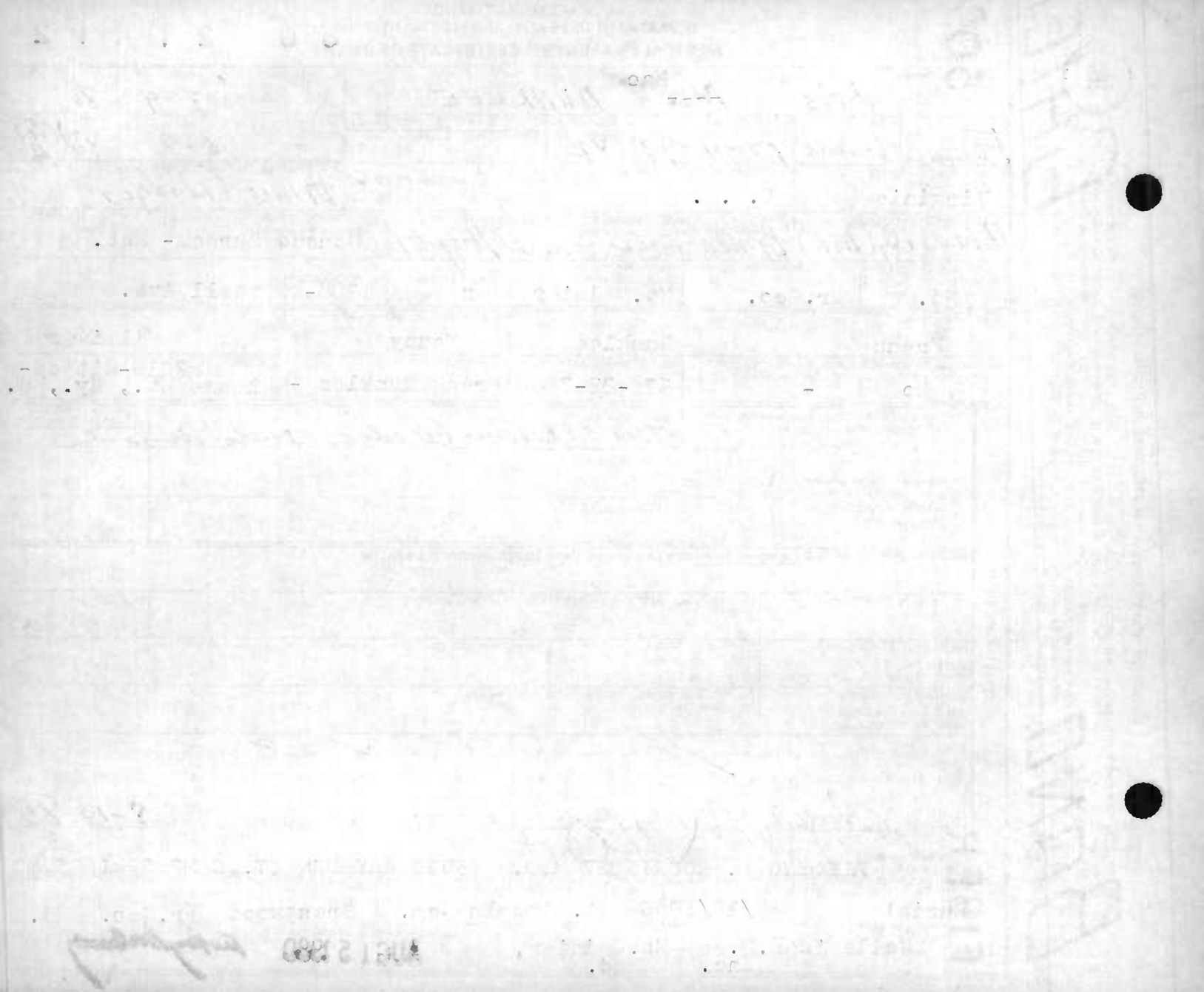
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM #M-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Lois Mae DUNKLEE</b>		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>8-9 19 80</b>		2b. HOUR <b>M</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12-4-27</b>	6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN <b>52 YRS.</b>	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. CITY OR TOWN OF DEATH <b>Cherry (D.A.)</b>		10. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Brimley General Hospital</b>		11. BALTIMORE CITY OR COUNTY OF DEATH <b>Brimley</b>
12. USUAL RESIDENCE (IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>		13b. COUNTY <b>Pr. Geo.</b>		13c. CITY OR TOWN <b>Mt. Rainier</b>
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4308- Russell Ave.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank Dunklee</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nanny Williams</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>578-22-7860</b>		17. INFORMANT ADDRESS <b>2016-Rittenhouse St., Hy., Md.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4292 Acute Coronary Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b>		TITLE (SPECIFY) <b>DEPUTY</b>		DATE SIGNED <b>8-10-80</b>
EXAMINER'S NAME (TYPE OR PRINT) <b>AUGUSTO P. RODRIGUEZ M.D.</b>		ADDRESS <b>5009 RAYBURN CT., CAMP SPRINGS, MD.</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/12/1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cem.</b>
23d. LOCATION CITY OR TOWN <b>Brentwood</b>		COUNTY <b>Pr. Geo.</b> STATE <b>Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Nalley's F.H. Inc.</b>		ADDRESS <b>Mt. Rainier, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 15 1980</b>
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				



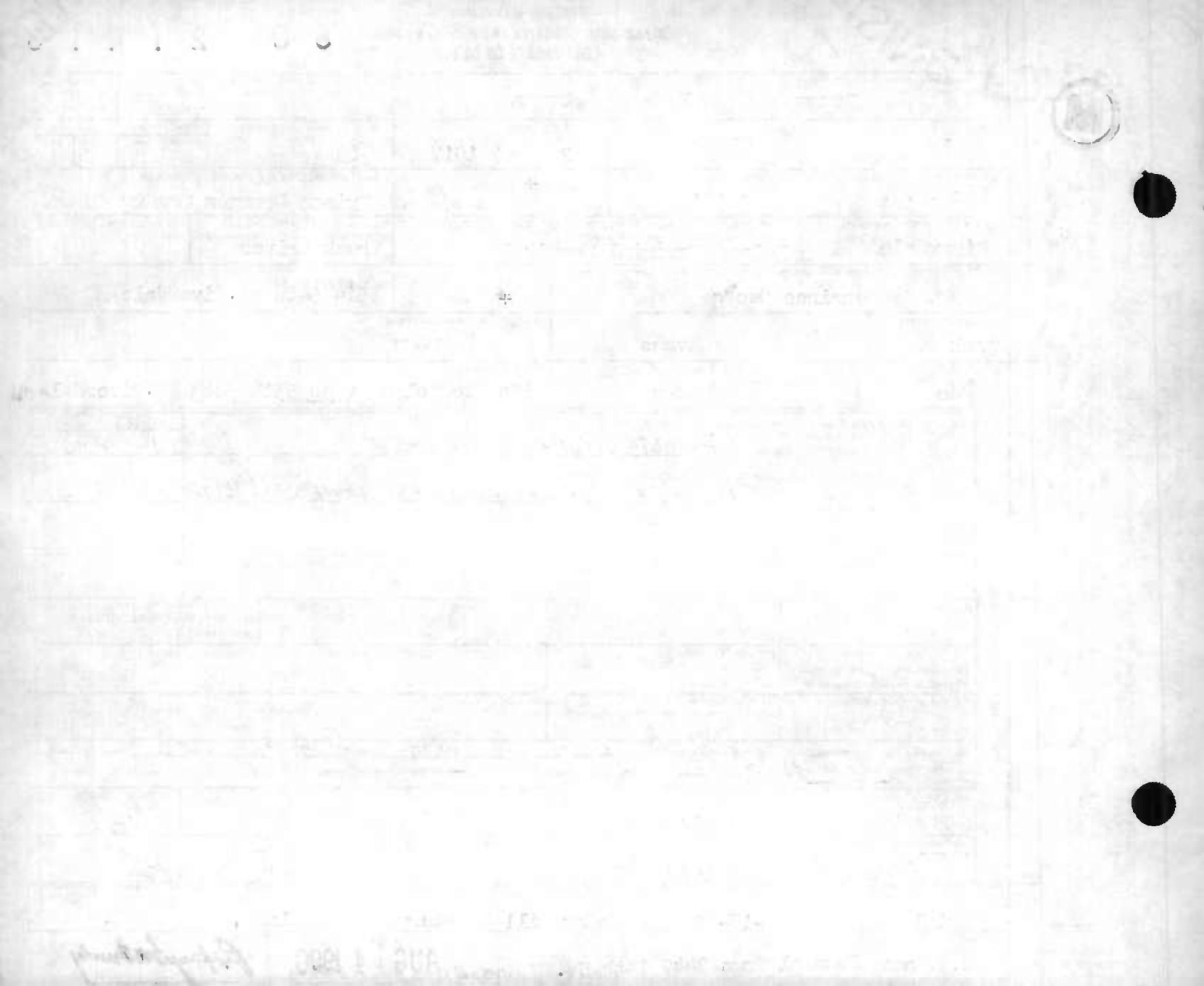
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 1 4 1 3 REG. NO.			
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) Raymond NMI Evans		2a. DATE OF DEATH MONTH DAY YEAR 8 13 80		2b. HOUR P M 7:05 P M	
3 SEX Male		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR 2 7 1917		6 AGE (IN YEARS LAST BIRTHDAY) 63 YRS. MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD	
10 CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.		13b. CITY OR TOWN prince George		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 5514 54th ST. Riverdale MD	
14 FATHER'S NAME FIRST MIDDLE LAST Jack Evans		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no			
16b. SOCIAL SECURITY NO. unknown		17 INFORMANT ADDRESS Wife Gwendolyn Evans 5514 54th ST. Riverdale Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> 1639 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>METASTATIC EPIDERMOID CARCINOMA OF LUNG</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>15 MOS</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 MIN</u>							PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <del>(the hospital)</del> attended the deceased from <u>MAY</u> 19 <u>79</u> to <u>AUG 13</u> 19 <u>80</u> , that (I) <del>(we)</del> lost <u>AUG 13</u> 19 <u>80</u> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) (did not) view the body after death.							
22b. SIGNATURE <u>James G. Brown</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>8/13/80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JAMES A. BROWN, MD</u>				22e. ADDRESS <u>6525 BELCREST RD HYATTSVILLE, MD 20782</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-18-80		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, MD.	
24 FUNERAL DIRECTOR NAME W.H. Bacon				ADDRESS Funeral Home 3447 14th ST. NW Wash. D.C.		25a. DATE REC'D. BY REGISTRAR AUG 14 1980	
				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



## MEDICAL EXAMINER NOTIFIED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8021414	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST WILLIAM		MIDDLE J.		LAST FARRELL		2a. DATE OF DEATH		MONTH DAY YEAR 08 21 80	
3 SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Oct 7 1905		6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS		7b. IF UNDER 1 YEAR MONTHS DAYS		7c. IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.					
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince Georges Gen. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Financial Analyst		12b. KIND OF BUSINESS OR INDUSTRY G.S.A.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Seabrook		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6805 96th Place			
14. FATHER'S NAME John		MIDDLE B.		LAST Farrell		15. MOTHER'S MAIDEN NAME Maude		MIDDLE -----		LAST Jenkins	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) N/A		17 INFORMANT Dorothea Farrell		ADDRESS Same as 13e					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> 4151 DUE TO, OR AS A CONSEQUENCE OF (b) <u>pulmonary embolus</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr 6 hr											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>ARTERIOSCLEROTIC HEART DISEASE, (Diagnosed 11/1/74)</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>9-19</u> , 19 <u>89</u> , to <u>8-21</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>8-21</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Roger Ingham M.D.</u>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8-21-80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROGER INGHAM M.D.		22e. ADDRESS 5701 85TH AVE. NEW CARROLLTON, MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-23-80		23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Clinton, Maryland					
24. FUNERAL DIRECTOR Beall F.H.		25a. DATE REC'D. BY REGISTRAR AUG 26 1980									
		25b. REGISTRAR'S SIGNATURE									







TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Margaret Catherine Ferguson</i>		20. DATE KNOWN OF DEATH ESTIMATED <i>8-28</i> 19 <i>80</i>		21. HOUR <i>5:45</i>
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH <i>6</i> - DAY <i>15</i> - YEAR <i>1958</i>	6. AGE (IN YEARS) LAST BIRTHDAY <i>22</i> YRS	7. IF UNDER 1 YR. MONTHS <i>0</i> DAYS <i>0</i> HOURS <i>0</i> MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Washington, DC</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
10. CITY OR TOWN OF DEATH <i>Chesapeake (POA)</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Prince Georges General Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Asst Vice Pres. Banking Ind</i>
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Pr Geo</i>	13c. CITY OR TOWN <i>Marlow Hgts</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST <i>Wister</i> MIDDLE <i>Wine</i> LAST <i>Wine</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Mary</i> MIDDLE <i>C</i> LAST <i>Armstrong</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>577 22 0028</i>		17. INFORMANT <i>Mary C Wine</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary heart failure</i> 1629 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>Cerebral aneurysm of the brain</i> DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>		TITLE (SPECIFY) <i>Deputy</i>		DATE SIGNED <i>8-28-80</i>
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez M.D.</i>		ADDRESS <i>5009 Rayburn Ct., Camp Springs, Md.</i>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>8-30-1980</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Ft Lincoln Cemetery</i>	23d. LOCATION CITY OR TOWN <i>Bladensburg</i>	COUNTY <i>Maryland</i>
24. FUNERAL DIRECTOR NAME <i>Robert E Wilhelm</i>		25a. DATE REC'D. BY REGISTRAR <i>SEP 4 1980</i>		25b. REGISTRAR'S SIGNATURE <i>Harry M. [Signature]</i>



*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some faint words like "RECEIVED" and "OFFICE" are visible.]*

*[Handwritten signature or initials at the bottom left corner.]*

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 50 21416			
1- FOR STATE REGISTRAR															
1. DECEASED NAME (TYPE OR PRINT) <b>LESTER LOUIS FIRESTONE</b>												2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> <b>8-7-80</b>		2b. HOUR M <input type="checkbox"/> AM <input type="checkbox"/>	
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> <b>Feb. 9, 1897</b>		6. AGE (IN YEARS) LAST BIRTHDAY <input type="checkbox"/> YRS. <input type="checkbox"/> <b>83</b>		IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> <b>8-7-80</b>		2d. HOUR M <input type="checkbox"/> AM <input type="checkbox"/>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>				7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE</b> MD.			
10. CITY OR TOWN OF DEATH <b>CLINTON</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SOUTHERN MD. HOSPITAL CTR.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOV'T</b>			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>PR. GEORGE</b>		13c. CITY OR TOWN <b>CAMP SPRING</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>5112 SILVER VALLEY WAY</b>							
14. FATHER'S NAME FIRST <input type="checkbox"/> MIDDLE <input type="checkbox"/> LAST <input type="checkbox"/> <b>BENJAMIN FRANKLIN FIRESTONE</b>												15. MOTHER'S MAIDEN NAME FIRST <input type="checkbox"/> MIDDLE <input type="checkbox"/> LAST <input type="checkbox"/> <b>MARY STONER</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <b>WW ONE</b>		17. INFORMANT <b>JEAN HENDRICK CAMP SPRINGS, MD.</b>				ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ante mortem vascular disease</b> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).															
MEDICAL CERTIFICATION															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b>				TITLE (SPECIFY) <b>Deputy</b>				MEDICAL EXAMINER <b>Augusto P. Rodriguez</b>				DATE SIGNED <b>8-8-80</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Augusto P. Rodriguez</b>				ADDRESS <b>5029 Camp Springs, Prince Georges</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>8/11/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Clinton Pr. Geo., Md.</b>					
24. FUNERAL DIRECTOR NAME <b>Charles F. Bell</b>						25a. DATE REC'D. BY REGISTRAR <b>735 AUG 15 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>							

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

4429 6 12119

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Flora Augusta FLORIN					2a. DATE OF DEATH MONTH DAY YEAR August 6 1980 7:45p <sub>M</sub>					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 12, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince-Georges MD.				
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerical		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY District of Columbia					13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3210 Wisconsin Ave., N.W.	
14. FATHER'S NAME FIRST MIDDLE LAST Paul Florin					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine <del>Preis</del> Preis					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-60-3496		17. INFORMANT 1053 E. Napier Henry Florin, Brother		ADDRESS Benton Harbor Michigan				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Cerebral Arterio Sclerosis</u> 20 yrs DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>3/10</u> to <u>Aug 6</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>Aug 5</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>J. Weill Kennedy</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-6-80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>J. Weill Kennedy</u>					22e. ADDRESS <u>1145-19 St. N.W., Wash. D.C. 20036</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-9-80		23c. NAME OF CEMETERY OR CREMATORY Crystal Springs Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Benton Harbor Michigan				
24. FUNERAL DIRECTOR NAME Robt E Wilhelm		24b. ADDRESS 4308 Suitland Rd., Suitland, Md.		25a. DATE REC'D. BY REGISTRAR AUG 15 1980		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

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2025-2026

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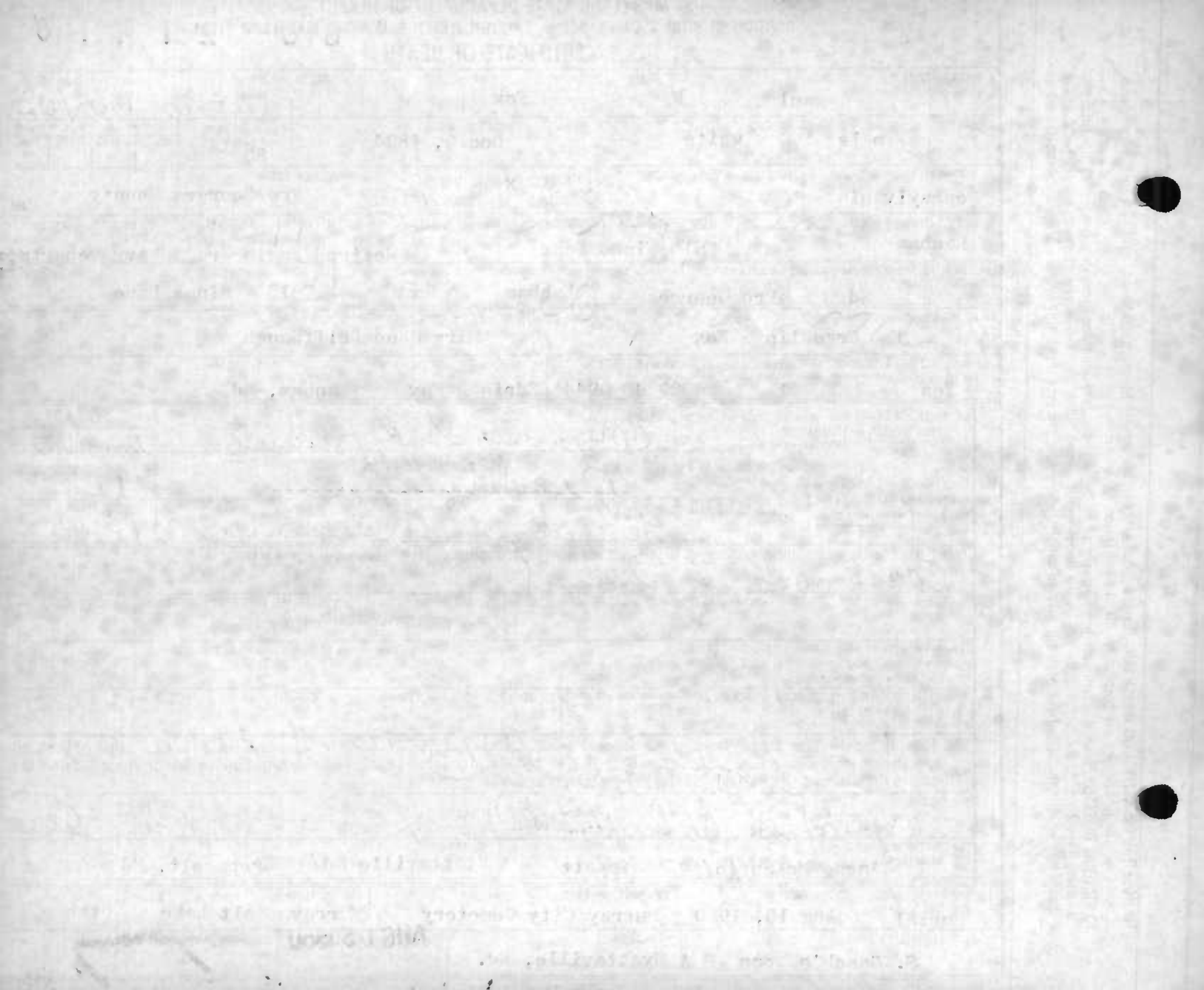


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>Item 186 G547 9/180 dad</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div>												
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR			
Paul F Fox						August 10 1980			10:45 AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
male		white		Dec 2, 1894		85 YRS.		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
Pennsylvania		U S A				Pro Georges County Md.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Lanham			7615 Finns Lane			Retired Engineer			Navy Department			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Md			Pro Georges		Lanham		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7615 Finns Lane			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME								
First Middle Last				First Middle Last								
Franklin S Fox				Mary Jane Deiffbaugh								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT							
Yes			W W 1		220 48 0944		Edris R Fox Lanham, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure										Immediate		
DUE TO, OR AS A CONSEQUENCE OF (b) Presbycusis										1 yr		
DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis										10 yr		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)												
Carcinoma of bowel												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)						
			HOUR A.M. Month Day Year									
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION						
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>						Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from August, 1972, to August, 1980, that (I) (we) lost saw the deceased alive on 26 Feb 1980 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.												
22b. SIGNATURE						22c. DATE SIGNED						
Angus McLaurin / Wm A Wimsatt						10 Aug - 80						
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS						
Angus McLaurin / Wm A Wimsatt						Hyattsville Md / Greenbelt, Md						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)						
Burial		Aug 15, 1980		Murray City Cemetery		Murray Salt Lake Utah						
24. FUNERAL DIRECTOR						25a. RECEIVED BY REGISTRAR			25b. REGISTRATION OFFICER			
F. Gasch's Sons P A Hyattsville, Md.						AUG 10 1980						





STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				80 21419 REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME FIRST MIDDLE LAST John C. Frasco, Jr.				08/10/80 10:55AM			
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 04/19/13		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 67	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Princes Georges MD.	
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired - Gov't.		12b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Prince Geo.		13c. CITY OR TOWN Hillcrest Sts	
14. FATHER'S NAME FIRST MIDDLE LAST John C. Frasco, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Antoinette Vallerio			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WWII 216-444-323		17. INFORMANT ADDRESS Hillcrest Hgts., Md. Pauline K. Frasco 4111 Norcross St.,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) ADENOCARCINOMA LUNG WITH METASTASES (b) (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
MEDICAL CERTIFICATION							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>8/19</u> 19 <u>80</u> to <u>8/10/80</u> 19 <u>80</u> , that (II) <u>we</u> last saw the deceased alive on <u>8/19</u> 19 <u>80</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> (did) (did not) view the body after death.							
22b. SIGNATURE <u>Philip Wisotsky</u> DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>8/10/80</u>			
23a. PHYSICIAN'S NAME (TYPE OR PRINT) Philip Wisotsky, M. D.				23b. ADDRESS 6188 Oxon Hill Rd., Oxon Hill, Md.			
23c. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23d. DATE 8/12/80		23e. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		23f. LOCATION CITY OR TOWN COUNTY STATE Clinton Pr. Geo. Maryland	
24. FUNERAL DIRECTOR George P. Kalas Funeral Home 6160 Oxon Hill Rd., Oxon Hill, Maryland				25a. DATE REC'D. BY REGISTRAR AUG 14 1980		25b. REGISTRAR'S SIGNATURE <u>Anthony McCreedy</u>	

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

and

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515.1725

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH 17  
(VR A15 ME (1))  
15M/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 8 0 2 1 4 2 0

1. FOR STATE REGISTRAR		2. DECEASED NAME (TYPE OR PRINT) <b>Frederick A. Frizzell</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>8</b> DAY <b>5</b> YEAR <b>1980</b>		2b. HOUR <b>M</b>			
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH <b>May</b> DAY <b>10</b> YEAR <b>1947</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>33</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH <b>8</b> DAY <b>5</b> YEAR <b>1980</b>		7d. HOUR <b>M</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Cheverly</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Prince George General Hospital</b>								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Roofer</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Montgy</b>		13c. CITY OR TOWN <b>Wheaton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>12023 Blue Hill Road</b>							
14. FATHER'S NAME FIRST <b>Alfred</b> MIDDLE LAST <b>Frizzell</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Hazel</b> MIDDLE LAST <b>Anderson</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>217-44-3838</b>		17. INFORMANT <b>Haxel Frizzell</b>				26723 ADDRESS <b>Ridge Rd</b>				Damascus, Md. 20750			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>Gun shot wound of head</b> <b>Gun: Unspecified</b>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <b>9654</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.																	
(b) <b>DUE TO, OR AS A CONSEQUENCE OF</b>																	
(c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY <b>approx. 3:30 PM 7/14 1980</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>subject shot</b>									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Shelterama</b>				21f. LOCATION STREET <b>GOCartTract</b> CITY OR TOWN <b>KenilworthAve</b> COUNTY <b>Bladensburg</b> STATE <b>PG, MD</b>									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <b>H.R. Guard</b>				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>8/7/80</b>									
EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>				ADDRESS <b>111 Penn Street, Balto., MD 21201</b>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Aug. 8, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>				23d. LOCATION CITY OR TOWN <b>Rockville</b> COUNTY <b>Montgy</b> STATE <b>Maryland</b>							
24. FUNERAL DIRECTOR NAME <b>W.W. Chambers</b>				ADDRESS <b>8655 Georgia Ave, Silver Spring, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 10 1980</b>				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. EXECUTE PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 80 21421	
FOR 1- STATE REGISTRAR													
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Anthony George Fullwood</b>						2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>AUGUST 8 21 19 80</b>		2b. HOUR M <b>7:09 P.M.</b>					
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>APR 4, 1962</b>		6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>18</b>		IF UNDER 1 YR. MONTHS DAYS <b>0 0</b>		IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>D.C.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County MD</b>				
10. CITY OR TOWN OF DEATH <b>Cheverly</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Prince George's General Hospital</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MORE THAN 10 YEARS) <b>STUDENT</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>SCHOOL</b>		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE <b>MD</b>		13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>BLADENBURGH</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5008 TOWNSENDWAY BLADENBURGH, MD</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN FULWOOD</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>DOROTHY MORRIS</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>UNK NONE</b>		17. INFORMANT ADDRESS <b>DOROTHY FULWOOD MOTHER 5008 TOWNSENDWAY</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thoraco Abdominal Injuries</b> Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last. (b) _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MONTH DAY YEAR <b>5:40 P.M. 8 21 19 80</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>passenger of motorcycle which impacted an automobile</b>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>street</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>5400 blk. Annapolis Rd., Bladensburg, Prince George's, Maryland</b>							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Virginia L. Dolan</i>				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>8-22-80</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>				ADDRESS <b>111 Penn Street</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>AUG 26, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LINCOLN MEMORIAL</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>SUITLAND, MD</b>			
24. FUNERAL DIRECTOR <b>ALEXANDER S. POPE</b>				25a. DATE RECEIVED BY REGISTRAR <b>AUG 28 1980</b>				25b. REGISTRAR'S SIGNATURE <i>Harry M. [Signature]</i>					



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51	52	53	54	55	56	57	58	59	60
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Section 1 of the Constitution

OFFICE OF THE  
COMMISSIONER OF  
THE  
REVENUE  
DEPARTMENT  
OF THE  
GOVERNMENT  
OF THE  
STATE OF  
NEW YORK



60-8386



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 2 1 4 2 2			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH MONTH DAY YEAR			
Ronald V. Gaines, Jr.				Aug. 10, 1980			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
MALE		BLACK		Aug. 10, 1980		9 hours	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Md.		USA				PRINCE GEORGES MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NO SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
CHEVERLY		PRINCE GEORGE'S GENERAL HOSPITAL		None			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS?			
13a. STATE 13b. CITY OR TOWN				13c. STREET ADDRESS			
Maryland Upper Marlboro				239 Harry S. Truman Drive			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
Ronald V. Gaines, Sr.				Georgia A. Howard			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT	
no				none		239 Harry S. Truman Drive Ronald V. Gaines, Sr.-Father-	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Respiratory failure							
DUE TO, OR AS A CONSEQUENCE OF							
(b) Hypoplastic lungs							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
Bilateral dysplastic kidneys							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/10/80, 19, to 8/10/80, that (I) (we) last saw the deceased alive on 8/10/80, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
Hoday at Stewart				MD. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		8-10-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
H. D. A. K. H.				Prince George's General Hospital			
23a. BURIAL, CREMATION (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY	
Burial		Aug. 18, 1980		Fort Lincoln Cemetery		Brentwood, Md.	
24. FUNERAL DIRECTOR NAME				25a. DATE BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Stewart Funeral Home-4001 Benning Road, NE				AUG 22 1980			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8021423	
1. FOR STATE REGISTRAR		REG. NO.									
1 DECEASED NAME (TYPE OR PRINT)					2a DATE OF DEATH					2b HOUR	
FIRST MIDDLE LAST GERTRUDE V. GIFFIN					MONTH DAY YEAR 08-09-80					8:55AM	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 03 31 1897			6 AGE (IN YEARS LAST BIRTHDAY) 83 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.				
10 CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES GENERAL HOSP.			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN md P.G. Co. Bladensburg					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 5437 Varnum St.				
14 FATHER'S NAME FIRST MIDDLE LAST Langdon - Allds					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Inez - Unknown						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO. None		17 INFORMANT 218-56-8129 Cheryl Allds (Niece)		ADDRESS Same as # 13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> 5520 DUE TO, OR AS A CONSEQUENCE OF (b) <u>aspiration pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>S/p. Encausated R femoral hernia and small blood ganglion</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION 7-27-80		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that this hospital attended the deceased from <u>Aug 9</u> , 19 <u>80</u> , to <u>Aug 9</u> , 19 <u>80</u> , that I have most saw the deceased alive on <u>Aug 9</u> , 19 <u>80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, I (we) did (do) not view the body after death.											
22b. SIGNATURE <u>Chambers Hony</u>					DEGREE M.D.			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8-11-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN W. HONY					22e ADDRESS Prince George Gen. Hospital, Cheverly md. 20906						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Aug/11/80		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G. Co., Maryland					
24 FUNERAL DIRECTOR NAME Chambers Funeral Home					ADDRESS Riverdale, Maryland		25. DATE REGD. BY REGISTRAR AUG 15 1980				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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(VRA 15, 4) 1/79TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8021424	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Edward Michael GIGERICH				2a. DATE OF DEATH MONTH DAY YEAR August 9, 1980			2b. HOUR 1:35a.m.		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MAY 23, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.					
10. CITY OR TOWN OF DEATH LANHAM		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES DOCTORS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY U.S. GOVERNMENT			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND				13b. COUNTY PRI. GEO.		13c. CITY OR TOWN LANHAM		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7015 DOLPHIN ROAD	
14. FATHER'S NAME FIRST MIDDLE LAST EDWARD GIGERICH				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JOSEPHINE ELLS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. WW II 160-01-6925		17. INFORMANT ENOLA W. GIGERICH				ADDRESS SAME AS 13 WIFE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOGENIC SHOCK.</u> <u>410 -</u> DUE TO, OR AS A CONSEQUENCE OF <u>ACUTE MYOCARDIAL INFARCTION</u> (b) <u>INTRACTABLE ARRHYTHMIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>OLD MYOCARDIAL INFARCTION</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION 8/7/80		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CARDIOGENIC SHOCK				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>8/8/80</u> to <u>8/9/80</u> , that (I) (we) last saw the deceased alive on <u>8/8/80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>A. S. RAO</u>				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/9/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. S. RAO				22e. ADDRESS DOCTOR S HOSPITAL LANHAM							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/12/80		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN		23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD PRI GEO MD.					
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901				25a. DATE REC'D. BY REGISTRAR AUG 14 1980		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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*Handwritten signature*

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FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21425									
1. DECEASED NAME (TYPE OR PRINT) <i>Helen Louise GRAY</i>										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 8-1 1980									
3. SEX <i>Female</i> 4. RACE <i>White</i> 5. DATE OF BIRTH MONTH DAY YEAR <i>9-4-17</i> 6. AGE (IN YEARS) LAST BIRTHDAY YRS. <i>62</i> 7. IF UNDER 1 YR. MONTHS DAYS 8. IF UNDER 24 HRS. HOURS MIN.										2c. DATE PRONOUNCED DEAD <i>8-1</i> 1980 2d. HOUR <i>3:15</i> M.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Washington DC</i>										7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>									
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i> MD.									
10. CITY OR TOWN OF DEATH <i>Chesley (DC)</i>										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Prince Georges General Hospital</i>									
12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <i>Housewife</i>										12b. KIND OF BUSINESS OR INDUSTRY									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. STATE <i>Maryland</i> 13b. COUNTY <i>Pr. Georges</i> 13c. CITY OR TOWN <i>Dist Hgts</i>									
14. FATHER'S NAME FIRST <i>James</i> MIDDLE <i>H</i> LAST <i>Ellis</i>										15. MOTHER'S MAIDEN NAME FIRST <i>Bertha</i> MIDDLE <i>A</i> LAST <i>Heutter</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i> (IF YES, GIVE WAR OR DATES)										16b. SOCIAL SECURITY NO. <i>577 14 5550</i>									
17. INFORMANT										ADDRESS <i>Owen F. Gray, Jr. Same as #13</i>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <i>4292</i> IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>																			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>									
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)									
21f. LOCATION STREET CITY OR TOWN COUNTY STATE																			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i> TIME (SPECIFY) <i>At night</i>										MEDICAL EXAMINER DATE SIGNED <i>8-1-80</i>									
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez</i>										ADDRESS <i>5009 Bayview Court, Camp Springs, Md.</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>										23b. DATE <i>8-5-1980</i>									
23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>										23d. LOCATION CITY OR TOWN COUNTY STATE <i>Suitland Maryland</i>									
24. FUNERAL DIRECTOR NAME <i>Robert E Wilhelm Funeral Home</i>										25a. DATE REC'D. BY REGISTRAR <i>AUG 11 1980</i>									
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>																			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



100-1-100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR		EDNA		FRANCES		REG. NO. 8021426			
1. DECEASED NAME (TYPE OR PRINT) Edna B. Brown						2a. DATE OF DEATH 8-23-80		2b. HOUR 7:00 PM	
3. SEX F		4. RACE W		5. DATE OF BIRTH 26 4-27-22		6. AGE (IN YEARS LAST BIRTHDAY) 58		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.			
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) So. Maryland General				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY St. Mary's		13c. CITY OR TOWN Mechanicsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 2, Box 19	
14. FATHER'S NAME FIRST MIDDLE LAST William D. Bowman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Geneva Bowman Robey					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-14-2035		17. INFORMANT ADDRESS John W. Graves, 2204 Green Harbour, Waldorf, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute hyaline infarction</u> 4029 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute renal infarction</u> 2 Day DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension with cerebral hemorrhage</u> year								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hr.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8-23-80 to 8-23-80, that (I) (we) last saw the deceased alive on 8-23-80, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Stephen S. S. M.D.				DEGREE M.D.				22c. DATE SIGNED 8-23-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-26-80		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel Grove, St. Mary's, Md.			
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley				ADDRESS Leonardtwn, Md.		25a. DATE REC'D. BY REGISTRAR AUG 26 1980		25b. REGISTRAR'S SIGNATURE Anthony McCreedy	

(M)



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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DHMH-16 20M  
(VRA 15, 4) 7/78

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 80 21427			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DONALD Utey GUNTER				2b. DATE OF DEATH MONTH DAY YEAR 8 19 80			
3 SEX male		4 RACE white		5. DATE OF BIRTH MONTH DAY YEAR May 17, 1911		6 AGE (IN YEARS LAST BIRTHDAY) 69	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Texas		7b. CITIZEN OF WHAT COUNTRY? U S A		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.	
10 CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GEN. HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Auto Parts	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Virginia				13b. COUNTY Pro William		13c. CITY OR TOWN Dumfries	
14 FATHER'S NAME FIRST MIDDLE LAST Unknown				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 577 24 5686		17 INFORMANT ADDRESS Gerald Wigle Hyattsville, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-Respiratory Failure</u> 2512 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Hypoglycemia (Insulin Rxn)</u> 6d. (c) <u>Hypoxic Brain Damage 20% aspiration</u> 6d. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <u>8/15</u> 19 <u>80</u> to <u>8/19</u> 19 <u>80</u> that (I) (we) last saw the deceased alive on <u>8/18</u> 19 <u>80</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22a. SIGNATURE Richard A. Marasa MD				DEGREE MD		22b. DATE SIGNED 8/19/80	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) RICK MARASA MD.				22d. ADDRESS P 66H Cheverly Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Aug 21, 1980		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pro Georges Md.	
24 FUNERAL DIRECTOR NAME F. Gasch's Sons P A				24b. ADDRESS Hyattsville, Md.		25a. DATE REC'D. BY REGISTRAR AUG 25 1980	
				25b. REGISTRAR'S SIGNATURE [Signature]			

UBB G. B. LLA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 80 21428	
1. FOR STATE REGISTRAR DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALVIN H. HALL					2a. DATE OF DEATH MONTH DAY YEAR 08-11-80			2b. HOUR 2:10AM			
3. SEX *Negro* Male		4. RACE Negro		5. DATE OF BIRTH July 31, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 58years		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.					
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL				12a. USUAL OCCUPATION (MOST OF WORKING LIFE) Porter		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE (IF COUNTY) Md. Br. Geo.					13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. STREET ADDRESS 5379 Quincy St. #2 Blandensburg, Md.				
14. FATHER'S NAME FIRST MIDDLE LAST Honor Hall					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Adams						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT 5379 Quincy St. #2 Jane Hall-wife Blandensburg, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia</u> 4255 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>alcoholic cardiomyopathy &amp; CHF</u> (c) <u>Chronic alcohol abuse</u> DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ① Left plural emphysema & generalized sepsis ② Generalized edema 2° to CHF											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>8-6</u> , 19 <u>80</u> , to <u>8-11</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>8-11-80</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>R. Rustagi, MD</u>				DEGREE MD				22c. DATE SIGNED <u>8/12/80</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAVINDER K. RUSTAGI, MD				22e. ADDRESS Prince George's Hospital Cheverly MD 20785							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 14, 1980		23c. NAME OF CEMETERY OR CREMATORY Harmony Mem.		23d. LOCATION Highland Pk. COUNTY Md. STATE					
24. FUNERAL DIRECTOR NAME H.S. Washington-4925 N.H. Burr. Ave N.E.						25a. DATE REC'D. BY REGISTRAR AUG 18 1980		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			





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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1 - FOR STATE REGISTRAR					8 0 2 1 4 2 9				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
Ethel HALL					8 24 80				
3. SEX FEMALE					2b. HOUR 5:50 PM				
4. RACE White					5. DATE OF BIRTH				
					MONTH DAY YEAR				
					89 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					6. AGE (IN YEARS LAST BIRTHDAY)				
CENTRALIA KANSAS					89				
7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				
U.S.					9. BALTIMORE CITY OR COUNTY OF DEATH				
UPPER MALBORO					PRINCE GEORGES MD				
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION				
					(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				
9115 Marlboro Pike #10					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				
					HOUSEWIFE				
12b. KIND OF BUSINESS OR INDUSTRY					13a. STREET ADDRESS				
AT HOME					Route 1				
13a. STATE KANSAS					13b. COUNTY CENTRALIA				
13c. CITY OR TOWN CENTRALIA					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
FRANK					MARY				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.				
NO					443-16-4246				
17. INFORMANT					ADDRESS				
PAUL NIGHTEEN GALE					9115 MARLBORO				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HEART FAILURE									
436- DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIAL SCLEROSIS									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 16a									
STROKE ADEPHAL INSUFFICIENCY, ARTERIOVALVE DISEASE PULMONARY EMPHYSEMA									
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				
					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY				
					HOUR A.M. MONTH DAY YEAR				
					P.M. 19				
21d. INJURY OCCURRED					21e. PLACE OF INJURY				
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK					(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				
21f. LOCATION					21g. HOW INJURY OCCURRED				
STREET					(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
CITY OR TOWN					COUNTY				
STATE									
22a. I certify that (I) (this hospital) attended the deceased from 19 78 to Aug 24 19 80, that (I) (we) lost saw the deceased alive on 8/21 19 80, and that in (my) opinion death occurred on the date and hour and from the causes stated above. (If (he) (she) (it) did not view the body after death, so state.)									
22b. SIGNATURE									
Joseph Peter CARUSO MD									
22c. DATE SIGNED									
8/24/80									
22d. ADDRESS									
9131 PISCATAWAY RD CLINTON, MD.									
23a. BURIAL (SPECIFY)									
Burial									
23b. DATE									
8/27/80									
23c. NAME OF CEMETERY OR CREMATORY									
Vermillion Cemetery									
23d. LOCATION									
Clinton, Maryland									
24. FUNERAL DIRECTOR									
NAME ADDRESS									
KALAS 6160 OXON HILL RD.									
25a. DATE REC'D BY REGISTRAR									
AUG 27 1980									



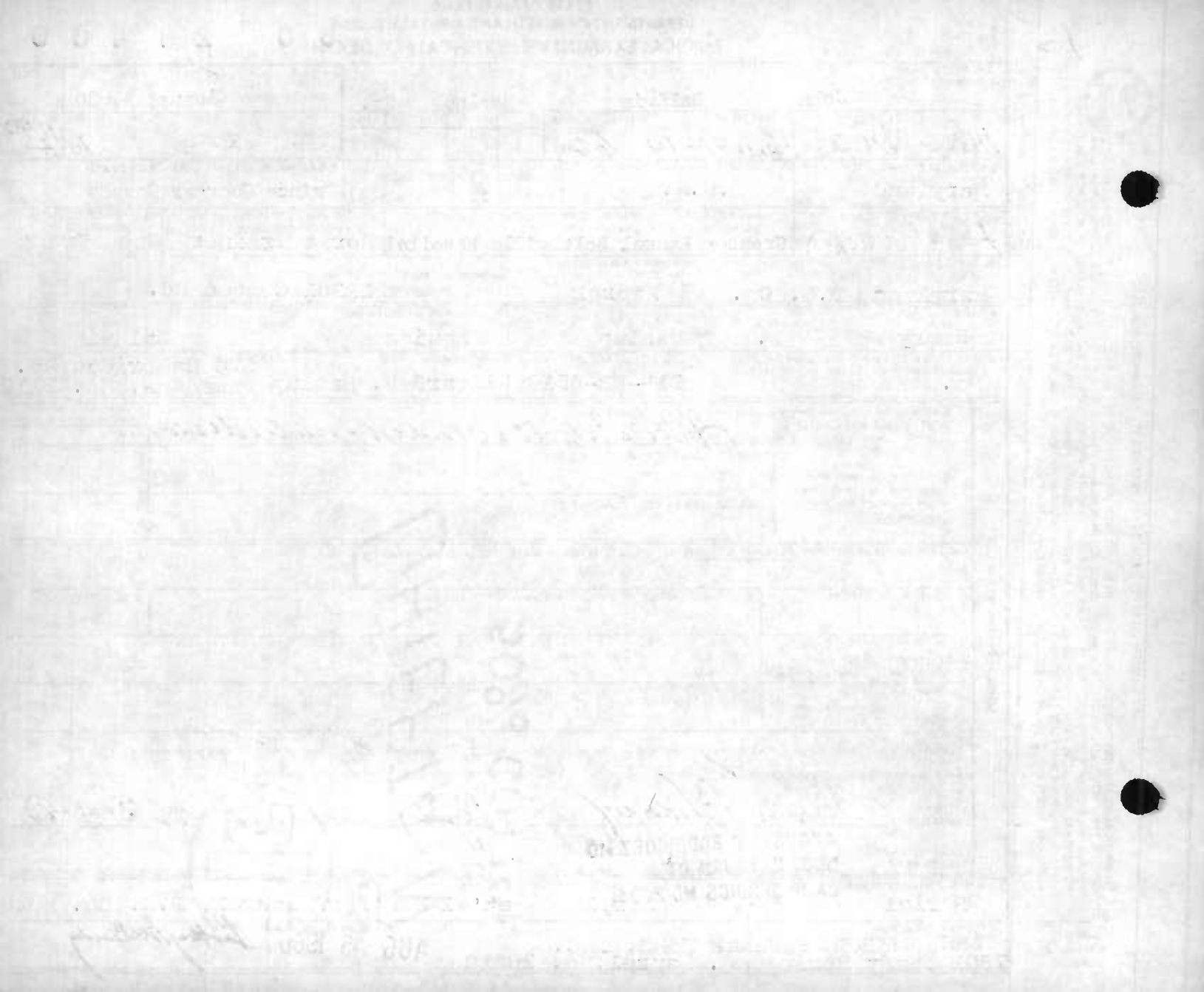
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 21430

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		REG. NO.		2b. HOUR	
John		Baldwin		Haslup		Sr.		MONTH DAY YEAR		August 3, 1980		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		9. DATE PRONOUNCED DEAD		10. HOUR	
Male	Male	MONTH DAY YEAR		LAST BIRTHDAY		MONTHS DAYS		HOURS MIN.		8-3		11/40	
11. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		12. CITIZEN OF WHAT COUNTRY?		13. MARRIED		14. NEVER MARRIED		15. BALTIMORE CITY OR COUNTY OF DEATH		16. DATE PRONOUNCED DEAD		17. HOUR	
Maryland		U.S.A.		WIDOWED		DIVORCED		Prince Georges County		8-3		11/40	
18. CITY OR TOWN OF DEATH		19. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		20. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		21. KIND OF BUSINESS OR INDUSTRY		22. BALTIMORE CITY OR COUNTY OF DEATH		23. DATE PRONOUNCED DEAD		24. HOUR	
Laurel (DOD)		Greater Laurel Beltsville Hospital		Horse Trainer		Race Tract		MD.		8-3		11/40	
25. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		26. STATE		27. COUNTY		28. CITY OR TOWN		29. INSIDE CITY LIMITS?		30. STREET ADDRESS		31. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		P.G. Co.		Laurel		YES		NO		13301 Contee Rd.		MD.	
32. FATHER'S NAME		33. MOTHER'S MAIDEN NAME		34. DATE OF OPERATION		35. CONDITION FOR WHICH OPERATION WAS PERFORMED?		36. AUTOPSY?		37. YES		38. NO	
Emory		Louise		19				YES		NO			
39. WAS DECEASED EVER IN U.S. ARMED FORCES?		40. SOCIAL SECURITY NO.		41. INFORMANT		42. ADDRESS		43. DATE OF OPERATION		44. CONDITION FOR WHICH OPERATION WAS PERFORMED?		45. AUTOPSY?	
No.		219-03-6518		Edward F. Haslup		324 Cambridge Rd.		19				YES	
46. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		47. PART 1 DEATH WAS CAUSED BY:		48. IMMEDIATE CAUSE (a)		49. DUE TO, OR AS A CONSEQUENCE OF		50. (b)		51. DUE TO, OR AS A CONSEQUENCE OF		52. (c)	
4292		Aspirin											
53. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1		54. 19a. DATE OF OPERATION		55. 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		56. 20. AUTOPSY?		57. YES		58. NO		59. DATE OF OPERATION	
		19				YES		NO				19	
60. 21a. EXTERNAL CAUSE WAS		61. 21b. TIME OF INJURY		62. 21c. HOW INJURY OCCURRED		63. 21d. LOCATION		64. 21e. PLACE OF INJURY		65. 21f. LOCATION		66. 21g. PLACE OF INJURY	
UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2		STREET CITY OR TOWN COUNTY STATE		STREET CITY OR TOWN COUNTY STATE		STREET CITY OR TOWN COUNTY STATE		STREET CITY OR TOWN COUNTY STATE	
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		21g. PLACE OF INJURY		21h. LOCATION		21i. PLACE OF INJURY		21j. LOCATION	
WHILE AT WORK		STREET, FACTORY, FARM, ETC.)		STREET		STREET		STREET		STREET		STREET	
22a. I certify that I took charge of the remains described above, held an		22b. Autopsy		22c. Inspection		22d. Inquiry		22e. and in my opinion		22f. death resulted from:		22g. Natural causes	
22a. I certify that I took charge of the remains described above, held an		22b. Autopsy		22c. Inspection		22d. Inquiry		22e. and in my opinion		22f. death resulted from:		22g. Natural causes	
22a. I certify that I took charge of the remains described above, held an		22b. Autopsy		22c. Inspection		22d. Inquiry		22e. and in my opinion		22f. death resulted from:		22g. Natural causes	
22a. I certify that I took charge of the remains described above, held an		22b. Autopsy		22c. Inspection		22d. Inquiry		22e. and in my opinion		22f. death resulted from:		22g. Natural causes	
22a. I certify that I took charge of the remains described above, held an		22b. Autopsy		22c. Inspection		22d. Inquiry		22e. and in my opinion		22f. death resulted from:		22g. Natural causes	
22a. I certify that I took charge of the remains described above, held an		22b. Autopsy		22c. Inspection		22d. Inquiry		22e. and in my opinion		22f. death resulted from:		22g. Natural causes	
22a. I certify that I took charge of the remains described above, held an		22b. Autopsy		22c. Inspection		22d. Inquiry		22e. and in my opinion		22f. death resulted from:		22g. Natural causes	
22a. I certify that I took charge of the remains described above, held an		22b. Autopsy		22c. Inspection		22d. Inquiry		22e. and in my opinion		22f. death resulted from:		22g. Natural causes	
22a. I certify that I took charge of the remains described above, held an		22b. Autopsy		22c. Inspection		22d. Inquiry		22e. and in my opinion		22f. death resulted from:		22g. Natural causes	
22a. I certify that I took charge of the remains described above, held an		22b. Autopsy		22c. Inspection		22d. Inquiry		22e. and in my opinion		22f. death resulted from:		22g. Natural causes	
22a. I certify that I took charge of the remains described above, held an		22b. Autopsy		22c. Inspection		22d. Inquiry		22e. and in my opinion		22f. death resulted from:		22g. Natural causes	
22a. I certify that I took charge of the remains described above, held an		22b. Autopsy		22c. Inspection		22d. Inquiry		22e. and in my opinion		22f. death resulted from:		22g. Natural causes	
22a. I certify that I took charge of the remains described above, held an		22b. Autopsy		22c. Inspection		22d. Inquiry		22e. and in my opinion		22f. death			



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR1. DECEASED NAME  
(TYPE OR PRINT)FIRST MIDDLE LAST  
*Eleanor Minerva HAY*2a. DATE KNOWN  
OF DEATH  
ESTIMATED ☒ MONTH DAY YEAR  
8-3 1980  
2b. HOUR  
M  
A

3. SEX

*Female*

4. RACE

*White*5. DATE OF BIRTH  
MONTH DAY YEAR*4-14-99*6. AGE (IN YEARS  
(LAST BIRTHDAY)*81* YRS.IF UNDER 1 YR.  
MONTHS DAYSIF UNDER 24 HRS.  
HOURS MIN.2c. DATE  
PRONOUNCED  
DEAD *8-3* 1980  
A M7a. BIRTHPLACE (STATE OR  
FOREIGN COUNTRY)*Wash., D.C.*

7b. CITIZEN OF WHAT COUNTRY?

*USA*8. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

*Prince Georges* MD.

10. CITY OR TOWN OF DEATH

*Chesley (P.A.)*11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)*Minister General Hospital*12a. USUAL OCCUPATION (TYPE OF WORK  
FOR MOST OF WORKING LIFE)*Housewife*12b. KIND OF BUSINESS  
OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

*Md.*

13b. COUNTY

*PG*

13c. CITY OR TOWN

*Bradbury Hgts*

13d. INSIDE CITY LIMITS?

☐ YES ☐ NO

13e. STREET ADDRESS

*4307 Torque Street*14. FATHER'S NAME  
FIRST MIDDLE LAST*Sumerseth S. Robey*15. MOTHER'S MAIDEN NAME  
FIRST MIDDLE LAST*Mary E. King*16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO, OR UNKNOWN)*No*

16b. SOCIAL SECURITY NO.

*577-84-7592*17. INFORMANT *4200 23rd Place, Hillcrest**Ray Dalmolin, Grandson Hgts, Md.*18. CAUSE OF DEATH (Enter only one cause of death for (a), (b), and (c).  
PART 1 DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*2507*

DUE TO, OR AS A CONSEQUENCE OF

*Diabetic hypertension caused stroke and disease*Conditions, if any, which  
gave rise to immediate  
cause (a) stating the under-  
lying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☐21a. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR  
CONTRIBUTING ☐ CAUSE OF DEATH21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY (AT HOME,  
STREET, FACTORY, FARM, ETC.)21f. LOCATION  
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion  
death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE*Augusto P. Rodriguez*

TITLE (SPECIFY)

*DEPUTY*DATE  
SIGNED*8-3-80*EXAMINER'S NAME  
(TYPE OR PRINT)*AUGUSTO P. RODRIGUEZ*

M.D. ADDRESS

*5009 RAYBURN CT., CAMP SPRINGS, MD*23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)*Burial*

23b. DATE

*8-6-80*

23c. NAME OF CEMETERY OR CREMATORY

*Epiphany Ch. Cem.*23d. LOCATION  
CITY OR TOWN*Forestville, P.G., Md.*

COUNTY

STATE

24. FUNERAL DIRECTOR  
NAME*Robt E Wilhelm*  
*Funeral Home*

4308 Suitland Rd., Suitland, Md.

25a. DATE RECEIVED BY REGISTRAR

*AUG 11 1980*

25b. REGISTRAR'S SIGNATURE

*Augusto P. Rodriguez*TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.  
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS  
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET,  
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

00011000



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 1 4 3 2

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Marietta Elizabeth Hayes</b>			2a. DATE OF DEATH MONTH <b>8</b> DAY <b>28</b> YEAR <b>1980</b>			2b. HOUR <b>2:05</b> MIN <b>A</b>					
3. SEX <b>F.</b>		4. RACE <b>W.</b>		5. DATE OF BIRTH MONTH <b>10</b> DAY <b>13</b> YEAR <b>1888</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Haven</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's</b> MD					
10. CITY OR TOWN OF DEATH <b>Mitchellville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Villa Rosa Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13a. STATE <b>MD</b>						13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Bryans Rd.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>unavailable</b> MIDDLE <b></b> LAST <b>Campbell</b>						15. MOTHER'S MAIDEN NAME FIRST <b>unavailable</b> MIDDLE <b></b> LAST <b>O'Boyle</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>215-56-9250</b>		17. INFORMANT <b>A. Dal Balcon</b> ADDRESS <b>Vista Rd. - Mitchellville, MD 20716</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary heart failure</b> <b>4140</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>4-5 yrs.</b>										PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>8-26</b> 19 <b>80</b> , to <b>present</b> 19 <b></b> , that (I) (we) last saw the deceased alive on <b>8-26</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Michael G. Hayes, M.D.</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>8-28-80</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MICHAEL G. HAYES</b>						22e. ADDRESS <b>827 Linden Ave. Balto. Md. 21201</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>8-30-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Charles Cem.</b>		23d. LOCATION CITY OR TOWN <b>Glymont, Charles, Md.</b> STATE <b></b>			
24. FUNERAL DIRECTOR NAME <b>Huntt Funeral Home</b> ADDRESS <b>Waldorf, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>SEP 4 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.





Shirley, Robert, Mary, Robert, Ed. SEP 4 1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHM - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 1 4 3 3

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		August 21 1980		6:45AM	
3 SEX male		4 RACE white		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)	
				Dec. 18, 1903		76	
7a. BIRTHPLACE (STATE OR FOREIGN)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
Germany		USA				Prince George County MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Laurel		Greater Laurel Beltsville Hospital		dental technician		self-employee	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md		Mont		Burtonsville		YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS			
FIRST MIDDLE LAST		FIRST MIDDLE LAST		3921 Dustin Road			
Gustav Heller		Kathrina Wittlinger					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS	
no		363 09 3166		Alice F. Heller		same as above	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)	
1539		carcinomatosis (colon cancer)					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
8-15-1980		Intestinal obstruction		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8-14 19 80, to 8-21 19 80, that (I) (we) last saw the deceased alive on 8-20 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		DEGREE		22c. DATE SIGNED			
22b. SIGNATURE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		8-21-80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
TRISTAN J. ORELLANO		321 Prince George St Laurel MD 20810					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Cremation		Aug. 22, 1980		Westview Memorial Park		Catonsville, Md	
24. FUNERAL DIRECTOR		ADDRESS		25a. DATE REG'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
				AUG 26 1980			

MEDICAL CERTIFICATION

29

1

97

84

35

150

2

1539

1539

1539

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1539

1539

1539

1539

1539

1539

1539

1539



male	white	Dec. 18, 1903	75
Germany	USA	X	
no	323 09 3156	Alice T. Heller same as above	
custav heller	xxxxx	Estelina Wittlinger	
font	fontonsville	X	
3921	3921	3921	
dentist technician self-employed			

Registration No. 23, 1900 Gustav Memorial Park, Fontonsville, Pa.

4162 000

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 1 4 3 4

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Anna (Ann) V. Hubbard		2a. DATE OF DEATH MONTH DAY YEAR August 30, 1980		2b. HOUR 11:50p M	
3 SEX Female	4 RACE Negro	5. DATE OF BIRTH MONTH DAY YEAR 8 14 11		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD		13b. CITY OR TOWN Baltimore	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS 8764 Mission Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST Richard Dunbar		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie Carter			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 217-09-2579		17. INFORMANT ADDRESS George H. Dunbar 2505 Liberty Hgts.	
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest.</u> 436- DUE TO, OR AS A CONSEQUENCE OF (b) <u>complication of massive CVA.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>7-19</u> , 19 <u>80</u> , to <u>8-30</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>8-30</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Michael C. Pistole</u>		DEGREE M.D.		22c. DATE SIGNED 8/31/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL C. PISTOLE		22e. ADDRESS 3301 CHAVERLY AVE CHAVERLY MD 20785			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/4/80		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. MD					
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave.				25a. DATE REC'D. BY REGISTRAR SEP 3 1980	
				25b. REGISTRAR'S SIGNATURE <u>Patricia Habrady</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100-100000



Medical Examiner Notified &amp; Approved

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 1 4 3 5

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WALTER E. HUTCHINSON</b>		<b>AUGUST 18, 1980</b>		<b>11:00 AM</b>	
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Feb 16, 1904</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b> MD.		
10. CITY OR TOWN OF DEATH <b>Hyattsville</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>5510 39th Avenue</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>US Gov't</b>		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Prince Geo.</b>	13c. CITY OR TOWN <b>Hyattsville</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>5510 39th Avenue</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Raymond Hutchinson</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Pansy P. Ogden</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN) <input checked="" type="checkbox"/> (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO <b>579-10-3392M</b>		17. INFORMANT ADDRESS <b>Vera B. Hutchinson (Wife) same as above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Generalized arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Parbinsonism Chronic Urinary Tract Infection (Pseudomonas)</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. LOCATION STREET CITY OR TOWN COUNTY STATE	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>7/29</b> 19 <b>80</b> to <b>8/18</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>7/29</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Paul B. Bender, M.D., FACS</b>				22c. DATE SIGNED <b>Aug. 18, 1980</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Paul B. Bender, M.D.</b>				22e. ADDRESS <b>4400 Stamp Road Marlo Heights, Md. 20031</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>8/21/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crematory</b>	
23d. LOCATION CITY OR TOWN <b>Brentwood Pr. Geo's</b>		23e. COUNTY <b>Md.</b>		23f. STATE	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons, PA Hyattsville, Md.</b>				25a. DATE REC'D BY REGISTRAR <b>AUG 22 1980</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				25c. DATE SIGNED	

24. FUNERAL DIRECTOR  
**Francis Gasch's Sons, PA Hyattsville, Md.**

25a. DATE REC'D BY REGISTRAR  
**AUG 22 1980**

25b. REGISTRAR'S SIGNATURE  
**[Signature]**





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 5,6,7a,7b G 547 9/23/80 GB

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 1 4 3 6  
REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
		FRANK G. TAQUINTA					08	11	80	7:22P.M.	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)	7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		
Male	Cauc.	9 MONTH 24 DAY 12 YEAR	67 74 YRS.	Texas Calabria		USA Italy	Prince Georges		MD.		
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Clinton	Southern Maryland Hospital		Retired		Barber						
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS						
Maryland		Pr. George's	Oxon Hill	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	3117 Tucker Road						
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17 INFORMANT		ADDRESS		
Umile		Iaquinta		Josephine		Puglisi	Helen E. Iaquinta		3117 Tucker Road Oxon Hill, Maryland		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY.		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		(b)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
410-		Acute Myocardial Infarction		Coronary Artery Heart Disease		10 years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
		7-29-80		Acute Cholecystitis with cholelithiasis		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21e. LOCATION STREET		CITY OR TOWN COUNTY STATE	
		P.M. 19									
22a. I certify that (I) (this hospital) attended the deceased from		22b. SIGNATURE		DEGREE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
7-1 1977 to 8-11 1980, that (I) (we) last saw the deceased alive on 8-8 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.		Thos F Cleary MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		8-13-80		Thomas F. Cleary, M. D.		9131 Piscataway Rd., Clinton, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		8/14/80		Ft. Lincoln Cemetery		Brentwood		Pr. Geo.		Md.	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. DATE REC'D. BY REGISTRAR		25d. REGISTRAR'S SIGNATURE			
George P. Kalas Funeral Home		6160 Oxon Hill Rd., Oxon Hill, Maryland		AUG 18 1980							

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3117 broken heads

Thomas J. O'Leary, L. D.

Thomas J. O'Leary, L. D.

Dec. 10, 1967

Dec. 10, 1967

Dec. 10, 1967

Dec. 10, 1967

Dec. 10, 1967

Dec. 10, 1967

Dec. 10, 1967

Dec. 10, 1967

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 1 4 3 7

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Blanche Cecelia JACKSON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>August 4, 1980</b>			2b. HOUR <b>5:30p</b> M			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 23, 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince-Georges</b> MD.			
10. CITY OR TOWN OF DEATH <b>Hyattsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sacred Heart Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Federal Govern.</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>13b. COUNTY</b> <b>District of Columbia</b>			13c. CITY OR TOWN <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4812-Illinois Ave., N.W.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Walter S. Jackson</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Blanche Wendlinger</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>578-32-4804</b>		17. INFORMANT ADDRESS <b>PAUL A. CLEMENS + SACRED HEART HOME</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Heart Stroke</b> <b>9000</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>2 years.</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Aug 6</b> , 19 <b>69</b> , to <b>Aug 4</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>Aug 4</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Thomas F. Collins</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8-4-80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>THOMAS F. COLLINS MD</b>			22e. ADDRESS <b>2600 Queens Chapel Road</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Aug 7, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Calvary Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Richmond Virginia</b>		
24. FUNERAL DIRECTOR NAME <b>John F. Collins</b>			ADDRESS <b>2544 14th St NW</b>			25. DATE REC'D. BY REGISTRAR <b>AUG 6 1980</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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August 1, 1950

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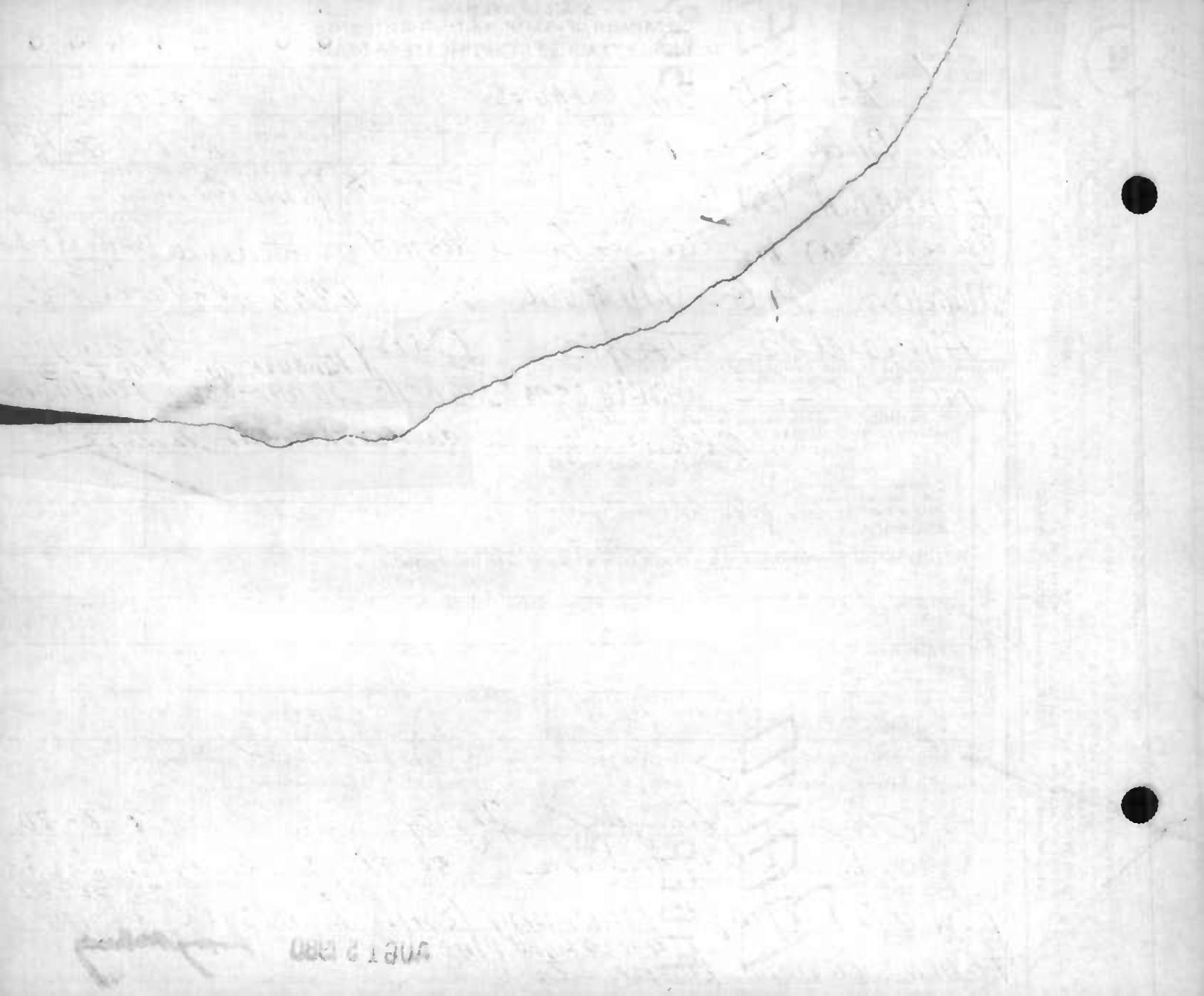
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE ORIGINAL. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 0 21438	
1. DECEASED NAME (TYPE OR PRINT) <i>Rowdell Bell JAMES</i>							20. DATE KNOWN OF DEATH ESTIMATED <i>8-8-80</i>		2b. HOUR <i>7:29</i>		
3. SEX <i>Male</i>	4. RACE <i>Black</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>6-20-13</i>	6. AGE (IN YEARS) LAST BIRTHDAY <i>67</i> YRS	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>8-8-80</i>	2d. HOUR <i>7:29</i>				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>ALABAMA</i>		7b. CITIZEN OF WHAT COUNTRY? <i>United State</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i>					
10. CITY OR TOWN OF DEATH <i>Bladely (MD)</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Prince Georges General Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <i>maintenance</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Pg-Ed of Educ</i>			
13a. STATE <i>Maryland</i>		13b. COUNTY <i>P. G.</i>		13c. CITY OR TOWN <i>Landover</i>		13d. HOME CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>6323 Landover Rd.</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Alexander James</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Daisy Brown</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>421-12-0570</i>		17. INFORMANT <i>Jeannette James-6323 Landover</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Atherosclerotic cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <i>4292</i> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>August P. Rodriguez</i>		TITLE (SPECIFY) <i>Deputy</i>				MEDICAL EXAMINER		DATE SIGNED <i>8-8-80</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>August P Rodriguez</i>		ADDRESS <i>5009 Baymont Court, Camp Springs</i>									
23a. BURIAL, CREMATION, REMOVAL		23b. DATE <i>8/12/80</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Harmony Cem.</i>		23d. LOCATION CITY OR TOWN <i>Landover</i>		COUNTY <i>Pg Md</i>		STATE	
24. FUNERAL DIRECTOR <i>Collins Funeral Home Inc</i>		ADDRESS <i>4339 Hunt Pk</i>		25a. DATE REC'D BY REGISTRAR <i>AUG 15 1980</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. IF YOU ARE THE CHIEF MEDICAL EXAMINER, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. IF YOU ARE THE CHIEF MEDICAL EXAMINER, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

BP

DHM-17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST <b>AARON R. JONES</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>8-18 1980</b>			2b. HOUR <b>10</b> M		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JAN. 6, 1900</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>80</b> YRS.		IF UNDER 1 YR. MONTHS DAYS <b>0 0</b>		IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prima Georges</b> MD.		
10. CITY OR TOWN OF DEATH <b>Riverdale (not)</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Iceland Memorial Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Electrician</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Electrical</b>		
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>						13b. COUNTY <b>P.G. Co.</b>		13c. CITY OR TOWN <b>Riverdale</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>5422 Kennilworth Terrace #1</b>											
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles R. Jones</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret E. Stall</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>216-44-9405</b>		17. INFORMANT ADDRESS <b>Donald R. Jones (Son) Same as # 13.</b>					
18. CAUSE OF DEATH (Enter only one cause pertaining to (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diabetic arteriosclerotic cardiovascular disease</b> 2507 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b> M.D.				TITLE (SPECIFY) <b>Augusto</b> MEDICAL EXAMINER				DATE SIGNED <b>8-18-80</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Augusto P. Rodriguez</b>				ADDRESS <b>5009 Rayburn Ct., Camp Springs, Md 20746</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Aug/21/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, P.G. Co., Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>Chambers Funeral Home</b>				ADDRESS <b>Riverdale, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 25 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony Matheny</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their piece remove carbon papers. Pages 1 and 2 should be filed without delay with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				80 21440			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR	
BERNICE JONES				08-27-80		2b. HOUR 10:05A <sub>M</sub>	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Female	Black	Jan. 1, 1947		33		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
N.C.	U.S.A.			PRINCE GEORGE'S COUNTY MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
CHEVERLY	PRINCE GEORGE'S GENERAL HOSPITAL			Houswife		none	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
13a. STATE 13b. COUNTY Maryland Prince Geo.				13c. CITY OR TOWN Seat Pleasant		13d. INSIDE CITY LIMITS? NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Glass				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Howell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
no		579-02-3653		husband		Seat	
				Eugene Jones 5916 Addison Rd. Pleasant			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> <u>4293</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>COMA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASYMMETRICAL SEPTAL HYPERTROPHY OF HEART</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8-19, 1980</u> , to <u>8-27, 1980</u> , that (I) (we) last saw the deceased alive on <u>8-27, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (or we did) (and we) view the body after death.							
22b. SIGNATURE <u>ELIAS J. GERTH</u> 22b. PHYSICIAN'S NAME (TYPE OR PRINT)				22c. DATE SIGNED <u>8/27/80</u>		22d. ADDRESS <u>PGCH Cheverly, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		Sept. 2, 80		Harmony Mem. Park		Landover Md.	
24. FUNERAL DIRECTOR <u>Hunt Funeral Home 1420 34th St. S.E.</u> Wash. D.C.				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Rickey McBrady</u>	
				SEP 15 1980			

10-02A

08-27-80

WYER

BERNICE

PRINCE GEORGE'S COUNTY

PRINCE GEORGE'S GENERAL HOSPITAL

CHEVERLY

M

SEP 1 1980

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (5))  
15M/7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2d. HOUR	
Paul A. Jones								8/11		19		80		3am		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
MALE	WHITE	2/25/01		79 YRS.						8/11		19		80		7am	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. NEVER MARRIED		10. WIDOWED		11. DIVORCED		12. BALTIMORE CITY OR COUNTY OF DEATH					
Tennessee		U.S.A.										Prince Georges				MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Riverdale		Leland Memorial Hospital		Salesman		Automobile											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md		Prince Geo.		Riverdale		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5611 Nicholson St #202									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Unknown		Jones		Unknown													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No		None		577-05-3293		Robert Jones (Son)		6419 62nd Place								Riverdale, Md.	
18. CAUSE OF DEATH (Enter only one cause pertaining to (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
4292																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input type="checkbox"/>		and in my opinion									
death resulted from:		Natural causes <input checked="" type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
Augusto P. Rodriguez		Deputy		8-11-80													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
Augusto P. Rodriguez M.D.		5009 Rayburn Ct., Camp Springs, Md.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE					
Cremation		Aug/13/80		Cedar Hill Crematory		Suitland, P.G. co., Maryland											
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Chambers Funeral Home		Riverdale, Maryland				AUG 15 1980											



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR (A. K. A. Frank Charles Jordan, STATE OF MARYLAND)											
DEPARTMENT OF HEALTH AND MENTAL HYGIENE											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
REG. NO. 21442											
1. DECEASED NAME (TYPE OR PRINT)			FIRST <b>Charles</b>			MIDDLE <b>F.</b>			LAST <b>Jordan, Sr.</b>		
3. SEX <b>Male</b>			4. RACE <b>White</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 21, 1899</b>			6. AGE (IN YEARS) LAST BIRTHDAY <b>80</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.C.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>August 5, 1980</b>		
10. CITY OR TOWN OF DEATH <b>Hyattsville</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6117 42nd. Place</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Electrician</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		
13a. STATE <b>Md.</b>			13b. COUNTY <b>P.G.</b>			13c. CITY OR TOWN <b>Hyattsville</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Sidney L. Jordan</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma (Last Name Unknown)</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			16b. SOCIAL SECURITY NO. <b>577-38-4133</b>		
17. INFORMANT <b>Ethel Jordan</b>			ADDRESS <b>Address Same as No# 13e.</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>As teropelutic candida vascular disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b>			TITLE (SPECIFY) <b>Deputy</b>			M.D. MEDICAL EXAMINER			DATE SIGNED <b>Aug. 5, 1980</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Augusto P. Rodriguez, M.D.</b>			ADDRESS <b>5009 Rayburn Ct. Camp Spring, Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>8-8-80</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood P.G. Md.</b>		
24. FUNERAL DIRECTOR NAME <b>F. Gasch's Sons F.H. P.A.</b>			ADDRESS <b>Hyatts. Md.</b>			25a. DATE REC'D. BY REGISTRAR <b>AUG 8 1980</b>			25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) M. ELLET JUDY					2a. DATE OF DEATH MONTH DAY YEAR 8 9 80				
3 SEX Male					4 RACE White				
5 DATE OF BIRTH MONTH DAY YEAR Sept. 11, 1889					6 AGE (IN YEARS LAST BIRTHDAY) 90 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia					7b. CITIZEN OF WHAT COUNTRY? U.S.A.				
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.				
10 CITY OR TOWN OF DEATH Riverdale					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Ieland Memorial Hospital				
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer					12b. KIND OF BUSINESS OR INDUSTRY Farming				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Florida					13b. COUNTY St. Lucie				
13c. CITY OR TOWN Ft. Pierce					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13e. STREET ADDRESS 1225 Wyoming Avenue									
14. FATHER'S NAME FIRST MIDDLE LAST Gilbert - Judy					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Leona - Pollock				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) None				
17. INFORMANT Dana Judy (Son)					ADDRESS 6414 Oakland Ave. Riverdale, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>pulmonary aspiration</u> 4280 DUE TO, OR AS A CONSEQUENCE OF (b) <u>congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>pneumonia</u>									
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21c. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>8/9</u> , 19 <u>80</u> , to <u>8/9</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>8/9</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>John R. Melnick</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> 22c. DATE SIGNED <u>8/9/80</u>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. John R. Melnick, M.D. 22e. ADDRESS 4404 Queensbury Rd. Riverdale, Maryland									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE Aug/12/80 23c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial Cem. 23d. LOCATION CITY OR TOWN COUNTY STATE Ft. Pierce, St. Lucie, Fla.									
24. FUNERAL DIRECTOR NAME ADDRESS Chambers Funeral Home Riverdale, Maryland 25a. FILED BY REGISTRAR AUG 9 1980 25b. RECORDING									

BP.

0001-6144

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Items 21a-22a G547 9/8/80 dad

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80

21444

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Dorothy Spaulding KILLIAN			2a. DATE OF DEATH MONTH DAY YEAR July 15, 1980			2b. HOUR 3:30a. MD			
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR Nov. 22, 1925		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.			
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerical		12b. KIND OF BUSINESS OR INDUSTRY DC Govt	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. COUNTY Pr. Geo Co		13c. CITY OR TOWN Bowie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Pearson Spaulding				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Harriet Ridley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. --		17. INFORMANT ADDRESS 242-34-0131 Marjorie Jones, 12613 Blackwell Lane					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>Cardio Respiratory failure.</u> DUE TO, OR AS A CONSEQUENCE OF (b). <u>INCREASED INTRACRANIAL PRESSURE - 10 DAYS</u> DUE TO, OR AS A CONSEQUENCE OF (c). <u>INTRACEREBRAL HEMORRHAGES, EDEMA 10 DAYS</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24-36 HRS</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>PULMONARY ATLECTASIS.</u>									
19a. DATE OF OPERATION 7/10/80		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED TRACHEOSTOMY				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR a.m. 7/5/80 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) Head injury - Fall at home					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) AT HOME		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from July 5, 1980, to July 15, 1980, that (I) (we) lost saw the deceased alone on July 11, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) see the body after death. Accident									
22b. SIGNATURE Arvin R. Ginde				DEGREE MD				22c. DATE SIGNED July 15/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARVIN R. GINDE.				22e. ADDRESS 4710 AWH PLACE, SUITE 510					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 7-16-80		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C. CAMP SPRING, MD			
24. FUNERAL DIRECTOR NAME Marshall's Funeral Home 4217 9th Street NW, Washington, D.C.				25a. DATE REC'D. BY REGISTRAR JUL 21 1980		25b. REGISTRAR'S SIGNATURE			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (S))  
15M/7/77

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME  
(TYPE OR PRINT)

FIRST MIDDLE LAST  
*Richard E KING*

2a. DATE KNOWN  
OF DEATH

ESTIMATED ☒ MONTH DAY YEAR  
*8-16 1980*

2b. HOUR

3. SEX

*Male Black*

5. DATE OF BIRTH

MONTH DAY YEAR  
*12-15-47*

6. AGE (IN YEARS)

(LAST BIRTHDAY)  
*37* YRS.

IF UNDER 1 YR.

MONTHS DAYS

IF UNDER 24 HRS.

HOURS MIN.

2c. DATE  
PRONOUNCED  
DEAD

MONTH DAY YEAR  
*8-16 1980*

2d. HOUR

7a. BIRTHPLACE (STATE OR  
FOREIGN COUNTRY)

*WASHINGTON DC*

7b. CITIZEN OF WHAT COUNTRY?

*UNITED STATES*

8. MARRIED

☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

*Principes Georges*

MD.

10. CITY OR TOWN OF DEATH

*ANDREWS AFB*

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
*MG USAF MEDCEN AAFB DC*

12a. USUAL OCCUPATION (TYPE OF WORK  
FOR MOST OF WORKING LIFE)

*RETIRED POLICE OFFICER*

12b. KIND OF BUSINESS  
OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

*MARYLAND*

13b. COUNTY

*PRNC GRGES*

13c. CITY OR TOWN

*DISTRICT HGTS*

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

*6610 ATWOOD ST APT 6 SE*

14. FATHER'S NAME

FIRST MIDDLE LAST  
*JAMES PROCTER*

15. MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST  
*PEARL KING*

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO, OR UNKNOWN)  
*YES*

16b. SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)  
*1966-1970*

17. INFORMANT

*579-64-5328*

ADDRESS

*MAMIE KING/WIFE 6610 ATWOOD ST SE #6*

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*42922*  
Conditions, if any, which  
gave rise to immediate  
cause (a) stating the under-  
lying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)  
DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR  
CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME,  
STREET, FACTORY, FARM, ETC.)

21f. LOCATION

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held an

Autopsy ☐Inspection ☒Inquiry ☒

and in my opinion

death resulted from: Natural causes ☒Accident ☐Suicide ☐Homicide ☐Undetermined manner ☐ACTUAL  
SIGNATURE

*Augusto P. Rodriguez*

TITLE (SPECIFY)

*Deputy*

MEDICAL EXAMINER

DATE  
SIGNED

*8-16-80*

EXAMINER'S NAME  
(TYPE OR PRINT)

*Augusto P. Rodriguez M.D.*

ADDRESS

*5009 Rayburn Ct., Camp Springs, Md.*

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

*Burial*

23b. DATE

*8-22-80*

23c. NAME OF CEMETERY OR CREMATORY

*Harmony Memorial Park Land*

23d. LOCATION  
CITY OR TOWN

*Landover, Md.*

STATE

24. FUNERAL DIRECTOR

*Marshall's Funeral Home Inc.*

25a. DATE RECEIVED BY REGISTRAR

*AUG 20 1980*

25b. REGISTRAR'S SIGNATURE



1000-0000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8021446		
1. FOR STATE REGISTRAR			REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH DAY YEAR		2b. HOUR	
Lawrence W Kinzer						8-19-80			2		25 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
MALE		NEGRO		MONTH DAY YEAR		87		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
VIRGINIA		U.S.A.				Pr. George MD.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
FORESTVILLE			REGENCY NURSING HOME			CHAUFFEUR						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. INSIDE CITY LIMITS?			13c. STREET ADDRESS						
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13c. STREET ADDRESS			
D.C.			YES <input type="checkbox"/> NO <input type="checkbox"/>			1339-VERMONT AVE, N.W.						
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST			FIRST MIDDLE LAST									
HENRY KINZER			RENA UNKNOWN									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS						
YES			W.W.I.			579-03 2492 EDITH W. KINZER - 1339-VERMONT AVE, N.W. D.C.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
1889 Cardio Respiratory Arrest										Instant.		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										2 wk.		
DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary Edema												
DUE TO, OR AS A CONSEQUENCE OF (c) Advanced Ca of Bladder										18 mo		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
Anemia												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
			P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/19/80 to 8/19/80, that (I) (we) last saw the deceased alive on 8/19/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. If (we) (I) did not view the body after death.												
22b. SIGNATURE										22c. DATE SIGNED		
KELVIN L MINCHIN										8/19/80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS		
KELVIN L MINCHIN										6188 OXON HILL RD OXON HILL MD.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL			8-25-80			MARYLAND NAT.			LAUREL PC MD.			
24. FUNERAL DIRECTOR NAME						24b. ADDRESS			25a. DATE RECEIVED BY REGISTRAR			
BARNES & MATTHEWS, INC						3619-14th ST, N.W.			AUG 25 1980			





RENA

AUG 2 1960

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 80 21447		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR
Margaret B. Kirisch						Aug. 5 80						7:00 P.M.
3 SEX	4 RACE		5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female	White		Oct 12 1886			93 YRS			MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			
Washington D C			U S A						PR Geo			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Greenbelt, Md			GREENBELT Convalesc Center						Housewife		Home	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md			Pro Georges		College Park		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4503 Amherst Road			
14 FATHER'S NAME					15 MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST					FIRST MIDDLE LAST							
Ernest Betz					Marjorie Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17 INFORMANT ADDRESS						
no			214 74 8289			Ernest G Betz Hartford Connecticut						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4349 Cerebral Infarction, Rt Hemisphere DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
			HOUR A.M. MONTH DAY YEAR									
			P.M. 19									
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION						
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>			(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			STREET CITY OR TOWN COUNTY STATE						
AT WORK AT WORK												
22a. I certify that (I) (the hospital) attended the deceased from April 1977 to October 8, 1980, that (I) (we) lost the deceased alive on 8-1-80 1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE						22c. DATE SIGNED						
W. L. Etienne, M.D.						8-5-80						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS						
W. L. Etienne, M.D.						College Park, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION		COUNTY STATE		
Burial			Aug 9, 1980		Cedar Hill Cemetery			Suitland		Pro Georges Md.		
24 FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR			
NAME F. Gasch's Sons P A						ADDRESS Hyattsville, Md.			AUG 11 1980			



1980 / 1981

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

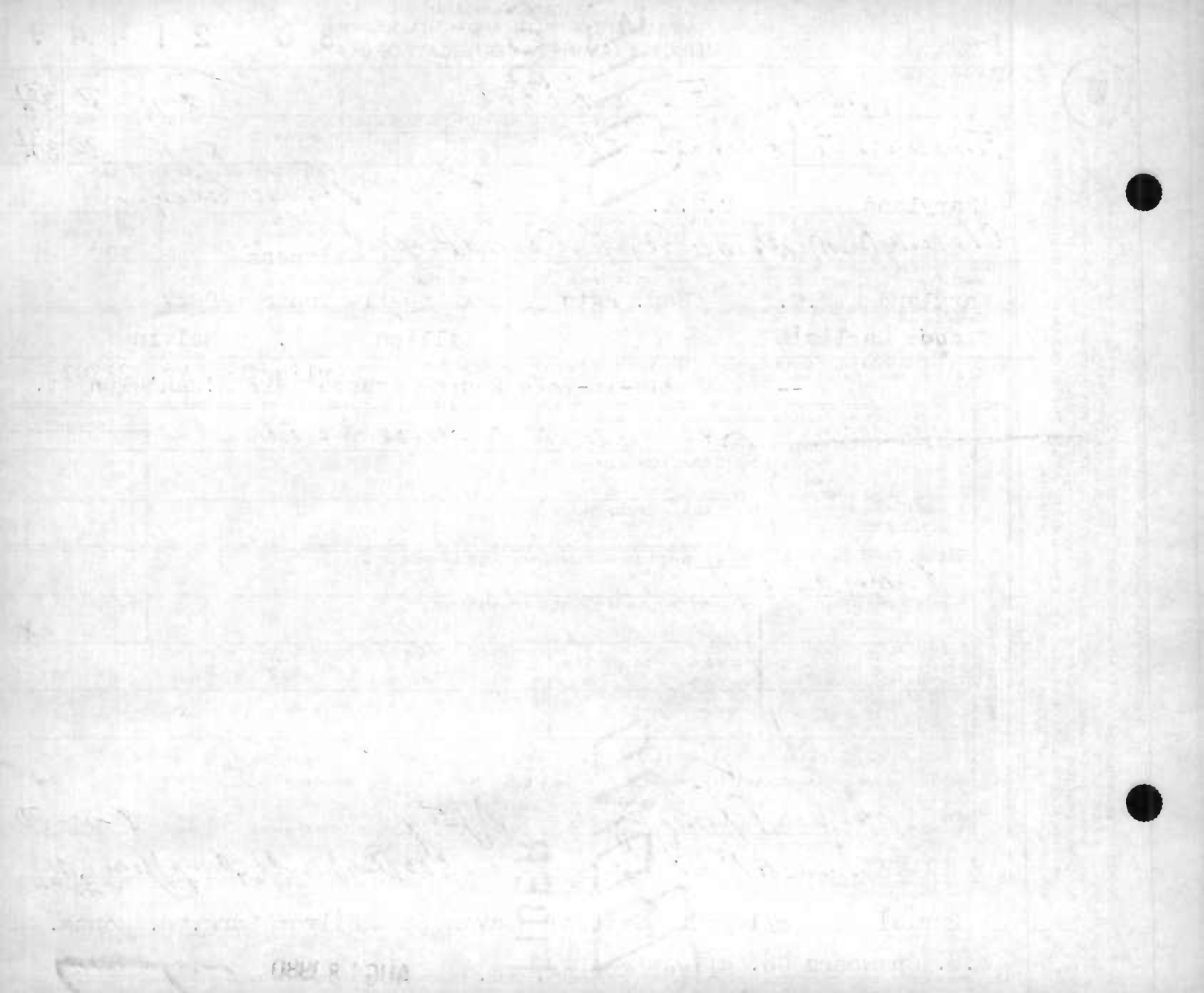
1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Annie</i>		MIDDLE <i>R.</i>		LAST <i>KOUWENBERG</i>		2a. DATE KNOWN OF DEATH ESTIMATED		MONTH <i>8-2</i>		DAY <i>19</i>		YEAR <i>80</i>		2b. HOUR <i>11</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH <i>8-2</i> DAY <i>05</i> YEAR <i>75</i>		6. AGE (IN YEARS) LAST BIRTHDAY <i>75</i> YRS.		IF UNDER 1 YR. MONTHS <i>0</i> DAYS <i>0</i>		IF UNDER 24 HRS. HOURS <i>0</i> MIN <i>0</i>		7c. DATE PRONOUNCED DEAD <i>8-2</i>		MONTH <i>19</i>		DAY <i>80</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>HOLLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i> MD.											
10. CITY OR TOWN OF DEATH <i>CHEVERLY</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>PRINCE GEORGES HOSPITAL</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOMEMAKER</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>HOME</i>											
13a. STATE <i>MD.</i>		13b. COUNTY <i>P.G. CO.</i>		13c. CITY OR TOWN <i>HYATTSVILLE</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>5007 70th AVE.</i>									
14. FATHER'S NAME FIRST <i>JULIUS</i>		MIDDLE <i>VANROON</i>		LAST <i>VANROON</i>		15. MOTHER'S MAIDEN NAME FIRST <i>FREDA</i>		MIDDLE <i>DeHAAN</i>		LAST <i>DeHAAN</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i>		(IF YES, GIVE WAR OR DATES) <i>-----</i>		16b. SOCIAL SECURITY NO. <i>577-09-6672</i>		17. INFORMANT <i>JACOB KOUWENBERG</i>		ADDRESS <i>SAME AS ITEM #13</i>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Intense acute Cardiovascular disease</i> 4292 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which } gave rise to immediate } cause (a) stating the under- } lying cause last. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>				TITLE (SPECIFY) <i>Deputy</i>				DATE SIGNED <i>8-2-80</i>									
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez M.D.</i>				ADDRESS <i>5009 Rayburn Ct., Camp Springs, Md.</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>				23b. DATE <i>8-5-1980</i>				23c. NAME OF CEMETERY OR CREMATORY <i>FT. LINCOLN CEMETERY</i>				23d. LOCATION CITY OR TOWN COUNTY STATE <i>BRENTWOOD, P.G.C. Md.</i>					
24. FUNERAL DIRECTOR NAME <i>W. W. CHAMBERS CO.,</i>				ADDRESS <i>RIVERDALE, Md.</i>				25a. DATE REC'D. BY REGISTRAR <i>AUG 7 1980</i>				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

U. S. 1 2 3 4 5

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 80 21449	
1. DECEASED NAME (TYPE OR PRINT) <b>Martha E. KRAFT</b>						2b. DATE KNOWN OF DEATH ESTI-MATED <input checked="" type="checkbox"/> 8-11 1980		2d. HOUR <b>3 31 A M</b>			
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>5-18-32</b>	6. AGE IN YEARS (LAST BIRTHDAY) <b>58</b> YRS	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD <b>8-11 1980</b>		2d. HOUR <b>3 31 A M</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. CITY OR COUNTY OF DEATH <b>Prince Georges</b> MD					
10. CITY OR TOWN OF DEATH <b>Chesapeake</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION <b>Prince Georges General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Waitress</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Food</b>			
13a. STATE <b>Maryland</b>						13b. CITY OR TOWN <b>Cap. Hgts</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME <b>Claude Carlisle</b>						15. MOTHER'S MAIDEN NAME <b>Lillian F. Melvin</b>		13e. STREET ADDRESS <b>19 Tunic 20027</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-10-7064</b>		17. INFORMANT <b>George Crabbe</b> ADDRESS <b>Arlington, Va. 22207</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>4292</b> IMMEDIATE CAUSE (a) <b>Unrelieved Cardiac Vascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Throat Cancer</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>August P. Rodriguez</b>		MEDICAL EXAMINER <b>August P. Rodriguez</b>		DATE SIGNED <b>8-11-80</b>							
EXAMINER'S NAME (TYPE OR PRINT) <b>August P. Rodriguez</b>		ADDRESS <b>5009 Bayhurst, Camp Springs, Md 20747</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/14/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION CITY OR TOWN <b>Silver Sprg. Md.</b> COUNTY <b>Montg.</b> STATE					
24. FUNERAL DIRECTOR NAME <b>W.W. Chambers Co.</b>		ADDRESS <b>Silver Spring, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 18 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 22 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21450	
1. DECEASED NAME (TYPE OR PRINT) <i>William J. KUMMEL</i>							2a. DATE KNOWN OF DEATH ESTIMATED <i>8-15-80</i>		2b. HOUR <i>2:30</i>		
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH <i>5</i> - DAY <i>14</i> - YEAR <i>1966</i>	6. AGE (IN YEARS) LAST BIRTHDAY <i>66</i> YRS.	IF UNDER 1 YR. MONTHS <i>0</i> DAYS <i>0</i>	IF UNDER 24 HRS. HOURS <i>0</i> MIN <i>0</i>	7c. DATE PRONOUNCED DEAD <i>8-15-80</i>	2d. HOUR <i>2:30</i>				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i> MD.					
10. CITY OR TOWN OF DEATH <i>Clinton (COA)</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION <i>Southern Maryland Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>LAUNDRY MANAGER</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>NAVAL ACADEMY</i>			
13a. STATE <i>MARYLAND</i>							13b. COUNTY <i>PRINCE GEORGES</i>		13c. CITY OR TOWN <i>HYATTSVILLE</i>		
14. FATHER'S NAME FIRST <i>WILLIAM</i> MIDDLE <i>KUMMEL</i> LAST <i>KUMMEL</i>							15. MOTHER'S MAIDEN NAME FIRST <i>THERESA</i> MIDDLE <i>KOENIG</i> LAST <i>KOENIG</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>YES</i>			16b. SOCIAL SECURITY NO. <i>WW II 213-01-0094</i>		17. INFORMANT ADDRESS <i>ANNE E. KUMMEL SAME AS 13 WIFE</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>42992 Sudden atherosclerotic cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>				TITLE (SPECIFY) <i>Deputy</i> MEDICAL EXAMINER				DATE SIGNED <i>8-16-80</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez M.D.</i>				ADDRESS <i>5009 Rayburn Ct., Camp Springs, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>			23b. DATE <i>8/19/80</i>		23c. NAME OF CEMETERY OR CREMATORY <i>SACRED HEART CEMETERY</i>			23d. LOCATION CITY OR TOWN <i>BALTIMORE</i> COUNTY <i>MARYLAND</i> STATE <i>MARYLAND</i>			
24. FUNERAL DIRECTOR'S NAME <i>FRANCIS J. COLLINS</i>						25a. DATE REC'D. BY REGISTRAR <i>AUG 18 1980</i>		25b. REGISTRAR'S SIGNATURE <i>Francis J. Collins</i>			
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901											

8 2 3 1 2 6 8

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT  
WASHINGTON, D. C. 20250

TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]

[illegible text block]

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[illegible text block]

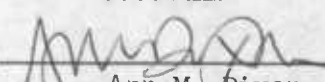



COPIES

BP  
DHMH - 17  
(VR A15 ME (5))  
15M 7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8 0 2 1 4 5 1	
1. DECEASED NAME (TYPE OR PRINT) <b>KWANE</b>						FIRST <b>KYLER</b>		MIDDLE		LAST	
3. SEX <b>male</b>		4. RACE <b>negro</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jun. 3, 1972</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>8</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>Aug. 18, 1980</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D. C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's Co.</b>		24. HOUR <b>6:52</b>		24. HOUR <b>6:52</b>	
10. CITY OR TOWN OF DEATH <b>Camp Springs, Md.</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Andrews Air Force Base Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>Student</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Prince Georges</b>		13c. CITY OR TOWN <b>Camp Springs</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5307 Chesterfield Drive</b>			
14. FATHER'S NAME FIRST <b>Phillip</b> MIDDLE <b>F.</b> LAST <b>Kyler</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Geraldine</b> MIDDLE <b>Washington</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT-- ADDRESS <b>Phillip F. Kyler 5307 Chesterfield Drive</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>7469 Congenital heart disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>8-19-80</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>				ADDRESS <b>111 Penn St.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Aug. 22, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Mem.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Alexander S. Pope</b>				ADDRESS <b>2617 PA. Ave, S. E.</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 25 1980</b>			
				25b. REGISTRAR'S SIGNATURE 							



14001 6 3307

• *E. coli*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 80 21452	
1. DECEASED NAME (TYPE OR PRINT) <b>Christopher John Lacey</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR <input type="checkbox"/> MIN <input type="checkbox"/> SEC		2b. DATE OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR <input type="checkbox"/> MIN <input type="checkbox"/> SEC		2c. DATE PRONOUNCED DEAD <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR <input type="checkbox"/> MIN <input type="checkbox"/> SEC	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Sept. 25 1947</b>		6. AGE (IN YEARS) <b>32</b> YRS.		7. IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> SEC. <input type="checkbox"/>		7c. DATE PRONOUNCED DEAD <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR <input type="checkbox"/> MIN <input type="checkbox"/> SEC	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.Y.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County, Md.</b>		
10. CITY OR TOWN OF DEATH <b>Lanham</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Doctor's Hospital (DOA)</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Metal Worker</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Alcoa Machine</b>		
13a. STATE <b>Md.</b>			13b. COUNTY <b>P.G.</b>			13c. CITY OR TOWN <b>Greenbelt</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME (FIRST MIDDLE LAST) <b>Gordon Lacey</b>			15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <b>Frances Jones</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>090-40-2452</b>		
17. INFORMANT <b>Gordon J. Lacey</b>			17. ADDRESS <b>112 Hawthorne Ave. Buffalo, N.Y.</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Blunt Injury to Trunk and Head</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>1:35xx 8 15 19 80</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Driver of motorcycle lost control</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>street</b>			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Rt. 495 Prince George's, Md.</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Virginia L. Dolan</b>			TITLE (SPECIFY) <b>Assistant</b>			DATE SIGNED <b>8/15/80</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>			ADDRESS <b>111 Penn Street</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>8-19-80</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Md. Veterans Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cheltenham, P. Md.</b>		
24. FUNERAL DIRECTOR NAME <b>F. Gasch's Sons, P.A.</b>			ADDRESS <b>Myattsville, Md.</b>			25a. DATE REC'D. BY REGISTRAR <b>AUG 19 1980</b>			25b. SIGNATURE <b>[Signature]</b>		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 1 4 5 3 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Mary Morley LAGOMARSINO				2a. DATE OF DEATH MONTH DAY YEAR August 8, 1980				2b. HOUR 11:10p am.			
3 SEX female		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR Aug 27, 1923		6 AGE (IN YEARS LAST BIRTHDAY) 56 YRS.		7 UNDER 1 YEAR MONTHS DAYS		8 UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan		7b. CITIZEN OF WHAT COUNTRY? U S A		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Pro George's County MD.					
10 CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dr Hospital of Pro Georges County				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md				13b. COUNTY Pro Georges		13c. CITY OR TOWN Lanham		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7021 Riverdale Road	
14 FATHER'S NAME FIRST MIDDLE LAST Frank Morley				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vera Werner							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579 24 3523		17 INFORMANT David J Lagomarsino				ADDRESS Lanham, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ventricular fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute myocardial infarct</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>diffuse atherosclerotic aortic valve disease</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (10), STATING THE UNDERLYING CAUSE LAST										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 16, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <u>5 June 80 July 19 63</u> to <u>Aug. 19 80</u> , that (1) (we) last saw the deceased alive on <u>5 June 80 July 19 63</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE James W Harding				22c. ADDRESS 6005 Landover Rd, Cheverly, Md.				22d. DATE SIGNED 8/9/80			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) James W Harding				22f. ADDRESS 6005 Landover Rd, Cheverly, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Aug 12, 1980		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pro Georges Md.			
24 FUNERAL DIRECTOR NAME F. Gasch's Sons P A Hyattsville, Md.				24b. ADDRESS Ft Lincoln Cemetery				25a. DATE REC'D. BY REGISTRAR AUG 13 1980		25b. REGISTRAR'S SIGNATURE [Signature]	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 0 2 1 4 5 4

1. DECEASED NAME (TYPE OR PRINT) <b>Mary M. Lannan</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8-30-1980</b>			2b. HOUR <b>10:45am</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 12, 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ireland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince-Georges</b> MD.			
10. CITY OR TOWN OF DEATH <b>Hyattsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sacred Heart Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Pro Georges</b>		13c. CITY OR TOWN <b>Hyattsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1906 Charleston Place</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Murray</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary M. Murray</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>577-42-8853</b>		17. INFORMANT ADDRESS <b>Elizabeth Jacobs Hyattsville, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>BRONCHIAL PNEUMONIA</b> <b>436 -</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CEREBRAL VASCULAR ACCIDENT</b> (c) <b>ARTERIOSCLEROSIS</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 DAYS</b> <b>14 DAYS</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>HYPERTENSION</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>OCT 12, 1978</b> to <b>AUG 30, 1980</b> , that (I) (we) lost saw the deceased alive on <b>AUG 20, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Roger J. Williams M.D.</b>				DEGREE <b>M.D.</b>				22c. DATE SIGNED <b>8/30/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROGER J. WILLIAMS</b>				22e. ADDRESS <b>5100 WISCONSIN AVE NW</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Sept 3, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington Arlington Va</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>F. Gasch's Sons P A Hyattsville, Md</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 5 1980</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MEDICAL CERTIFICATION

29

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITH THE DEATH CERTIFICATE. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI- DEATH MATED		MONTH		DAY		YEAR		2b. HOUR			
Mildred R. LANNING								8-8		1980						M			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
Female	White	July 27, 1910		70 YRS.						8-8		1980						M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH										MD	
Washington D C		U S A						Prime Georges											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Chesapeake (DCA)		Prime Georges General Hospital		Telephone operator		Hospital													
USUAL RESIDENCE (IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS									
Md		Pro Georges		Hyattsville						4722 68th Place									
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST									
Edward		McMahon				Gertrude		Harrison											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS															
no		219 01 0365		Regina G Lanning		Hyattsville, Md.													

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular disease</u> 4029 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		DATE (SPECIFY)		DATE SIGNED	
Augusto P. Rodriguez		M.D. Deputy		8-8-80	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
Augusto P. Rodriguez		5009 Payson Court, Camp Springs, Md. 20746			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		Aug 12, 1980		Resurrection Cemetery	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR	
F. Gasch's Sons P A		Hyattsville, Md.		AUG 13 1980	
				25b. REGISTERED BY	
				[Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Body released by Dr. Rodriguez

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR		
Walter L. Layne				8-6-80				1:00a		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 UNDER 1 YEAR		
Male		White		May 28 1936		44		MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH				
Wash., D. C.		USA				Prince George's County, MD.				
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Clinton		Southern Maryland Hospital				Truck Driver				
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		
Md.				PG		Clinton		YES <input type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				
Percy Layne				Pearl L. Chapple		No				
16b. SOCIAL SECURITY NO.				17 INFORMANT ADDRESS						
679-46-3510				June F. Layne, Wife, Same as Above						
18 CAUSE OF DEATH (Enter only one cause per line for part 1 and 2)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Brain Tumor Int. Cranial bleed</u>										
4329										
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardio pul arrest</u>										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Intra-cranial hemorrhage</u>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
			HOUR A.M. MONTH DAY YEAR							
			P.M. 19							
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION		21g. CITY OR TOWN		
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>						STREET		COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>8-5</u> 19 <u>80</u> , to <u>8-6</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>8-6</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE			DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
<u>Dr. Rodriguez</u>			MD						8-7-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS				
Dr. Abulhasan Ansari						10905 Ft. Wash. Dr., Oxon Hill, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial			8-11-80		Cedar Hill Cem.		Suitland, P.G., Md.			
24 FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Robt E Wilhelm						4308 Suitland Rd., Suitland, Md.		AUG 15 1980		









TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 2 1 4 5 8			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Ann</b> FIRST <b>T.</b> MIDDLE <b>Link</b> LAST				2a. DATE OF DEATH MONTH <b>August</b> DAY <b>20</b> YEAR <b>1980</b>		2b. HOUR <b>1:50 P</b> M	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>Apr</b> DAY <b>30</b> YEAR <b>1893</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash., D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's</b> MD.	
10. CITY OR TOWN OF DEATH <b>Clinton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Southern Maryland Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk - U.S. Gov't.</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE <b>Md.</b>		13b. COUNTY <b>PG</b>		13c. CITY OR TOWN <b>Cap. Hgts</b>		13e. STREET ADDRESS <b>424 Balboa Avenue</b>	
14. FATHER'S NAME FIRST <b>Frank</b> MIDDLE <b>J.</b> LAST <b>Link</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Susie</b> MIDDLE <b>Kinder</b> LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>579-60-4868</b>		17. INFORMANT <b>Lois L. Eversull, Niece</b> ADDRESS <b>13119 Oriole Dr., Beltsville, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Dehydration</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Medical Examiner Notified &amp; Will Appear.</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>8/18/80</b> to <b>8/20/80</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>8/18/80</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>J. H. Thibadeau</b>				DEGREE		22c. DATE SIGNED <b>Aug. 21, 1980</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Joseph H. Thibadeau, M.D.</b>				22e. ADDRESS <b>3112 Alabama Ave., S.E., Wash., D. C.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8-23-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, P.G., Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Robt E Wilham</b> ADDRESS <b>4308 Suitland Rd., Suitland, Md.</b>				25a. DATE RECEIVED BY REGISTRAR <b>AUG 26 1980</b>		25b. REQUIRED BY LAW	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21459			
1- FOR STATE REGISTRAR													
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Anthony J. Long, Jr.						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 8 3 1980		2b. HOUR M					
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Apr. 2, 1980		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 4 1		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 8 3 1980			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD					
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY -					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Pr. Geo. 13c. CITY OR TOWN Riverdale										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5023-Riverdale Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST Anthony J. Long					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anne Marie Trewolla								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. None			17. INFORMANT ADDRESS Anthony J. Long (above address) (Father)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 7980 IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE Thomas D. Smith, M.D.				TITLE (SPECIFY) Deputy Chief				DATE SIGNED 8-4-80					
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 8/7/1980		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Wash., D.C.			
24. FUNERAL DIRECTOR NAME Nalley's F.H. Inc.				ADDRESS Mt. Rainier, Md.				25a. DATE REC'D. BY REGISTRAR AUG 11 1980					
				25b. REGISTRAR'S SIGNATURE [Signature]									

11 AUG 1960



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST Sally			MIDDLE Delphine			LAST Love			2b. DATE KNOWN OF DEATH ESTIMATED			MONTH 8			DAY 6			YEAR 1980			2d. HOUR M								
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH SEPT. 22, 1952			YEAR 27 YRS.			6. AGE (IN YEARS) (LAST BIRTHDAY)			IF UNDER 1 YR. MONTHS DAYS HOURS MIN.			IF UNDER 24 HRS.			2c. DATE PRONOUNCED DEAD			MONTH 8			DAY 7			YEAR 1980			2d. HOUR 4:31 P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.				7b. CITIZEN OF WHAT COUNTRY? United States				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD.																				
10. CITY OR TOWN OF DEATH Cheverly				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital (DOA)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK				12b. KIND OF BUSINESS OR INDUSTRY DRUG STORE																				
13a. STATE D.C.										13b. COUNTY				13c. CITY OR TOWN WASHINGTON				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 3145 APPLE ROAD, N. E.										
14. FATHER'S NAME FIRST JAMES E. LOVE SR.										MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST FRANCES MIDDLE SHELTON LAST																		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				(IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO. 577-98-8568				17. INFORMANT WILBURN ESTATES, CAPITOL HGTS. JAMES E. LOVE SR./408 QUARRY PLACE MD.																				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Stab Wound of Back</b> 966- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(b)			
(c)			

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 8 6 19 80		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject found stabbed	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 2612 Pinebrook Ave., Kentland, P.G., Md.	

22a. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Virginia L. Dolan</u>		TITLE (SPECIFY) Assistant		DATE SIGNED 8/8/80	
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.		ADDRESS 111 Penn Street			

23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 8/13/80		23c. NAME OF CEMETERY OR CREMATORY WASHINGTON NAT. CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE AUG 15 1980	
24. FUNERAL DIRECTOR Name Collins Funeral Home Inc.				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 2 1 4 6 1		
1. FOR STATE REGISTRAR					REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) Josephine Lowell					2a. DATE OF DEATH MONTH DAY YEAR August 10 1980					2b. HOUR 5 <sup>50</sup> A M		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 4 16 88		6. AGE (IN YEARS LAST BIRTHDAY) 92		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.						
10. CITY OR TOWN OF DEATH Largo		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care Nursing home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Inspec. Bureau of Engrav.			12b. KIND OF BUSINESS OR INDUSTRY U. S. Gov. Retir.			
13a. STATE BOWEX Md.		13b. COUNTY Pr, Geo.		13c. CITY OR TOWN Bowie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 12502 Keynote La.				
14. FATHER'S NAME FIRST MIDDLE LAST George Yoe					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma C. Mahaney					16. SOCIAL SECURITY NO. 578-46-5775		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					17. INFORMANT James W. Lowell					17a. ADDRESS Box 309A Rt. 1 Sunderland, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute cardio respiratory failure</u> 1749 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Met stc breast carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>[Signature]</i>					DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED 8/10/80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Andrew Anders					22e. ADDRESS 3308 Dodge Park Rd Andrews MD 20724							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-13-80		23c. NAME OF CEMETERY OR CREMATORY St. John Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Mont. Md.				
24. FUNERAL DIRECTOR NAME Beall Funeral Home					24b. ADDRESS 16,000 Annapolis Rd. Bowie, Md.			25. DATE REC'D BY REGISTRAR AUG 18 1980		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

MEDICAL CERTIFICATION

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16,000 Annapolis Rd. Bowie, Md.

Beall Funeral Home

8-13-80

St. John Cemetery

Silver Spring, Mont. Md.

No

278-46-2775

James W. Lowe 11 Sunderland, Md.

George

Yoc

Emma

C.

Mahoney

Box 309A Rt. 1

U. S. Gov. Rept.

XXXXXX Md. Pr. Geo. Bowie

12502 Keynote La.

Large

Manor Care Nursing Home

Inspe. Bureau of Engrav.

Wash. D.C.

U.S.A.

x Prince George

Female

Caucasian

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

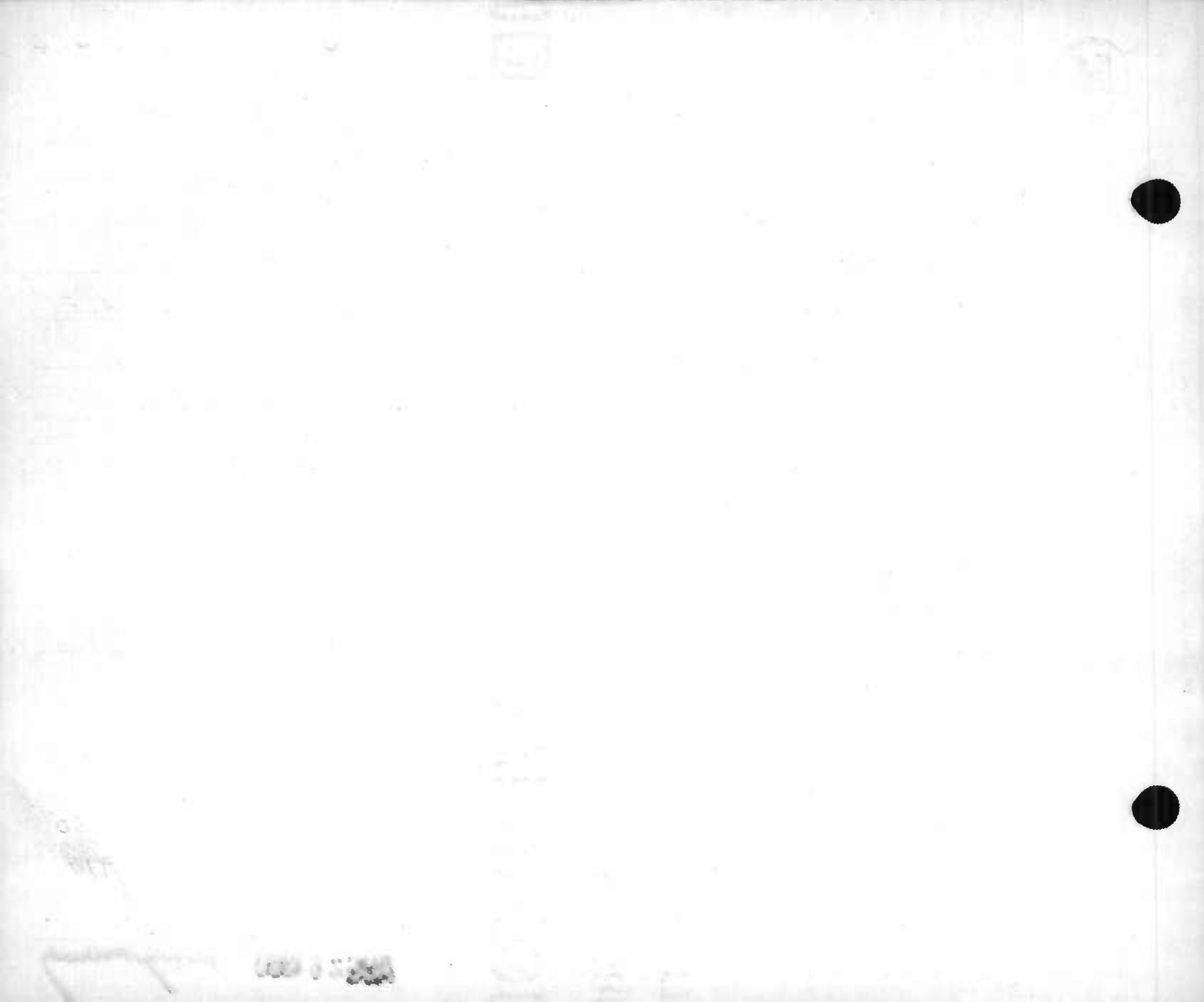
DHMH-16 20M  
(VRA 15, 4) 7/78

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8021462

REG. NO.

1- FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Jessie D Luck		2a DATE OF DEATH MONTH DAY YEAR 8 17 80		2b HOUR 6 55 AM	
3 SEX FEMALE		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR 5 22 1904		6 AGE (IN YEARS LAST BIRTHDAY) 76 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH P.G.	
10 CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wash. Adventist Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE		12b. KIND OF BUSINESS OR INDUSTRY	
13a STATE MD		13b COUNTY P.G.		13c CITY OR TOWN SILVER SPRING		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST unk		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CORA JOHNSON		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 577-44-2275	
17 INFORMANT ADDRESS Audrey Brown 8500 New Hampshire Ave #350		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction 2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) congestive Heart Failure (c) Diabetes PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 8/6/19 80 to 8/17/19 80, that (I) (we) lost saw the deceased alive on 8/16/19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b SIGNATURE Tony P. KANNARKAT M.D.		22c DATE SIGNED 8/17/80			
22d PHYSICIAN'S NAME (TYPE OR PRINT) TONY P. KANNARKAT		22e ADDRESS 8901 16th St S.S. MD 20910		22f ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Buryal		23b DATE 8-22-80		23c NAME OF CEMETERY OR CREMATORY Arlington National		23d LOCATION CITY OR TOWN COUNTY STATE Arlington VA.	
24 FUNERAL DIRECTOR NAME JOHNSON & JENKINS		24b ADDRESS 716 KENNEDY ST. N.W.		25a DATE REC'D. BY REGISTRAR AUG 26 1980		25b REGISTRAR'S SIGNATURE [Signature]	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
FOR STATE REGISTRAR											
1- DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY DOROTHEA Lutz R.J.M. (Sister) <del>Dorothea</del> <del>xxx</del>											
2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		8 26 80		2b. HOUR		M			
3. SEX		4. RACE		5. DATE OF BIRTH (MONTH DAY YEAR)		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
female		white		MAY 18, 1932		48 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
NEW YORK				U.S.A.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Joland RIVERDALE				Leland Memorial Hospital				TEACHERS AIDE		RELIGIOUS NUN	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
MARYLAND		PRINCE GEORGES		HYATTSVILLE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3006 GUMWOOD DRIVE			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
HENRY LUTZ				DOROTHY MULLANEY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS			
NO				079-26-3172				SR. LOIS KIMBER 8909 RIGGS ROAD HYATTSVILLE, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: Arteriosclerotic cardiovascular disease										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) 4292											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
				P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>H. Guard</i>				TITLE (SPECIFY) Assistant				DATE SIGNED 8/28/80			
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.				ADDRESS 111 Penn Street, Balto., MD 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 8/29/80		23c. NAME OF CEMETERY OR CREMATORY REGINA CONVENT CEMETERY				23d. LOCATION CITY OR TOWN COUNTY STATE HYATTSVILLE PRI GEO MD.	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				25a. DATE REC'D. BY REGISTRAR SEP 2 1980				25b. REGISTRAR'S SIGNATURE <i>History Kelly</i>			
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901											



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12/10/1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMM-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7. REG. NO.		8. 0		2. 1		4. 6		4. 4	
1. DECEASED NAME (TYPE OR PRINT) JOHN HARRY MALONEY				2a. DATE OF DEATH AUGUST 8 1980				2b. HOUR 12:35 A			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH SEPT 2 1922		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.		7. UNDER 1 YEAR MONTHS DAYS		7. UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) FLORIDA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD					
10. CITY OR TOWN OF DEATH ANDREWS AFB		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MALCOLM GROW USAF MED CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Military			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND				13b. COUNTY CALVERT		13c. CITY OR TOWN DUNKIRK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 9903 GREENING CT	
14. FATHER'S NAME JOHN HARRY MALONEY				15. MOTHER'S MAIDEN NAME EMILY NELLE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 1942-68		17. INFORMANT HELEN MALONEY		17. ADDRESS 9903 GREENING CT					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac &amp; Respiratory Arrest</u> <u>1590</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Probable Septicemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Adenocarcinoma of the Bowel</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>4 days</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE <u>Joyce D. Leone</u>				DEGREE D.O.				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8 Aug 80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joyce D. Leone, CAPT, USAF, MC				22e. ADDRESS MALCOLM GROW MEDICAL CTR. AAFB							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/12/80		23c. NAME OF CEMETERY OR CREMATORY Arlington National				23d. LOCATION CITY OR TOWN COUNTY STATE Ft. Myer, Arlington Va.			
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Clinton, Md. 20735				25a. DATE REC'D. BY REGISTRAR AUG 11 1980		25b. REGISTRAR'S SIGNATURE <u>Richard McCreedy</u>					

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 80 21465			
1- STATE REGISTRAR										2a. DATE KNOWN OF DEATH		2b. HOUR	
10. DECEASED NAME (TYPE OR PRINT) <i>William M. MARTIN</i>										ESTIMATED <input checked="" type="checkbox"/> 8-22-80		1980	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>5-4-92</i>		6. AGE (IN YEARS) <i>88</i> YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>New York</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i>		10. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE STREET ADDRESS) <i>Pr. Georges General Hospital</i>		11. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <i>Operator</i>			
12. CITY OR TOWN OF DEATH <i>Chesley (MD)</i>		13. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (GIVE STREET ADDRESS) <i>Pr. Georges General Hospital</i>		14. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE STREET ADDRESS) <i>Pr. Georges General Hospital</i>		15. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <i>Operator</i>		16. KIND OF BUSINESS OR INDUSTRY <i>Telephone</i>		17. TELEPHONE			
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Pr. Georges</i>		13c. CITY OR TOWN <i>Camp Spings</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>4908 Sharon Road</i>		14. FATHER'S NAME			
14. FATHER'S NAME FIRST <i>Frank</i>		MIDDLE <i>J.</i>		LAST <i>Lorey</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Mary</i>		MIDDLE <i>King</i>		LAST <i>King</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>578-03-3047</i>		17. INFORMANT <i>Patricia L. Brooke Same as #13 a-e.</i>		ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Lymphoma</i> 2028 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>				TITLE (SPECIFY) <i>Deputy</i> M.D. MEDICAL EXAMINER				DATE SIGNED <i>8-22-80</i>					
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez M.D.</i>				ADDRESS <i>5009 Rayburn Ct., Camp Springs, Md.</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>Aug 26, 1980</i>				23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cem</i>					
23d. LOCATION CITY OR TOWN <i>Wheaton</i>				COUNTY <i>Montgomery</i>				STATE <i>Md.</i>					
24. FUNERAL DIRECTOR NAME <i>Lee Funeral Home, Inc.</i>				ADDRESS <i>6633 Old Alexander Ferry Rd. Clinton, Md</i>				25a. DATE REC'D. BY REGISTRAR <i>SEP 2 1980</i>					
25b. REGISTRAR'S SIGNATURE <i>...</i>													



## Medical Examiner Notified &amp; Released

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 1 4 6 6

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Alexander G. Masaros</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>August 4, 1980</b>			2b. HOUR MIN. <b>12:49 P M</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>October 23, 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b>		8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.J.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>P.G.</b> MD.			
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Pr. Geo. Gen. Hosp.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Excavator</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Excavation</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>			13b. CITY OR TOWN <b>P.G.</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>7749 Garrison Road</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Michael Masaros</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sophia Lazar</b>			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] <b>No</b>			
16b. SOCIAL SECURITY NO. <b>577-26-3327</b>			17. INFORMANT <b>Mary B. Masaros</b>			ADDRESS <b>Address Same as No# 13e.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>4/40</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arterio-sclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes Mellitus</b> Approximate interval between onset and death: <b>5 years</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Diabetes Mellitus</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>July 17, 1980</b> to <b>8/4, 1980</b> , that (I) (we) last saw the deceased alive on <b>July 17, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Jack P. Segal</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>Aug. 5, 1980</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jack P. Segal, M.D.</b>						22e. ADDRESS <b>5530 Wisconsin Ave. Chevy Chase, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>8-7-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood P.G. Md.</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>F. Gasch's Sons F.H. P.A. Hyattsville, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG 5 1980</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION





2. *Psychology of Learning and Motivation*, Vol. 12, Academic Press, New York, 1978, pp. 1-100.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Medical examiner notified and approved

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					8021467 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary A. McCabe					2a. DATE OF DEATH MONTH DAY YEAR 8 9 80 2b. HOUR 12:06 P M					
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR March 31, 1884		6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.				
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK OR HOSE OF WORKING LIFE) Dress Making		12b. KIND OF BUSINESS OR INDUSTRY Seamstress		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md					13b. CITY OR TOWN Pro Georges		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 6008 Westchester Park Dr.	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Butler					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emily Suit					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578 34 4061A		17. INFORMANT ADDRESS Eada McCabe College Park, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive heart failure 4280 DUE TO, OR AS A CONSEQUENCE OF (b) (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (2 weeks duration) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) decubitus										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) this hospital attended the deceased from 7/1 1950 to 8/9 1950, that (1) I saw the deceased alive on 8/9 1950, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.										
22b. SIGNATURE John R Melnick					DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 8/9/50		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John R Melnick					22e. ADDRESS 4400 Queensbury Rd. Riverdale, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Aug 12, 1980		23c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington D C			
24. FUNERAL DIRECTOR NAME F. Gasch's Sons P A Hyattsville, Md.					25a. DATE REC'D. BY REGISTRAR AUG 3 1980		25b. REGISTRAR'S SIGNATURE Eada McCabe			

BP



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DHMH - 17  
(VR A15 ME (5))  
15M/7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 80 21468	
1. DECEASED NAME (TYPE OR PRINT) <b>Bessie J. McCauley</b>										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 8-25-80										2b. HOUR M	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 29, 1931</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>49</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD <b>8-25-80</b>		7d. HOUR M		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Pr. Geo. Co.</b> MD					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				10. CITY OR TOWN OF DEATH <b>Hyattsville</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>8010 Riggs Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Claim Supervisor</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Ins. Co.</b>	
13a. STATE <b>Md.</b>										13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Hyattsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>8010 Riggs Road</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Williams</b>										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rachael Hoffman</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>215-26-3760</b>				17. INFORMANT <b>Robert B. McCauley</b>				ADDRESS <b>Address Same as No# 13e.</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxiation to Aspiration of gastric contents</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Bronchogenic carcinoma with radiation therapy</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b>				TITLE (SPECIFY) <b>Deputy</b>				MEDICAL EXAMINER				DATE SIGNED <b>Aug. 25, 1980</b>									
EXAMINER'S NAME (TYPE OR PRINT) <b>Augusto P. Rodriguez, M.D.</b>				ADDRESS <b>5009 Rayburn Ct. Camp Springs, Md.</b>																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>				23b. DATE <b>8-28-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crematory</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood P.G. Md.</b>											
24. FUNERAL DIRECTOR NAME <b>F. Gasch's Sons F.H. P.A.</b>										ADDRESS <b>Hyattsville, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 27 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Robert B. McCauley</b>							

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Medical Examiner Notified

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death.

1 - FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 0 2 1 4 6 9 REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) JAMES MC LEAN		2a DATE OF DEATH MONTH DAY YEAR 08-10-80		2b HOUR 6:10A M	
3 SEX Male	4 RACE Black	5 DATE OF BIRTH MONTH DAY YEAR December 20, 1959		6 AGE (IN YEARS LAST BIRTHDAY) 20 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.	
10 CITY OR TOWN OF DEATH CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGE'S GENERAL HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) D.C. Recreation Department		12b KIND OF BUSINESS OR INDUSTRY
13a STATE Maryland		13b CITY OR TOWN Landover	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Franklin D. McLean		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ernestine Esters			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. 215-78-7041		17 INFORMANT ADDRESS Ernestine McLean 3129 75th Avenue	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>lymphoepithelioma of Nasopharynx</u> 1479 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Transverse myelitis</u> 2 YRS. 7 mo. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Sickle Cell Disease</u> 20 YR.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Pneumonia, Maxillary sinusitis</u>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (1) this hospital attended the deceased from <u>Nov 76</u> , to <u>Aug 10</u> , 19 <u>80</u> , that (1) (we) last saw the deceased alive on <u>8-9-</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22a SIGNATURE <u>Joseph Mireo Jr. MD</u>		DEGREE MD		22c DATE SIGNED 8-10-80	
22b PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH MIREO JR. MD		22e ADDRESS THE JOHNS HOPKINS HOSPITAL			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b DATE August 15, 1980		23c NAME OF CEMETERY OR CREMATORY Harmony Memorial Park, Landover, Md	
24 FUNERAL DIRECTOR NAME Stewart Funeral Home 4001 Benning Rd., N.E.		25a DATE REC'D. BY REGISTRAR AUG - 8 1980		25b REGISTRAR'S SIGNATURE	





1948

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M/7/77

FOR STATE REGISTRAR												DEPARTMENT OF HEALTH AND MENTAL HYGIENE																																																																																			
1- STATE REGISTRAR												MEDICAL EXAMINER'S CERTIFICATE OF DEATH																																																																																			
1. DECEASED NAME (TYPE OR PRINT)						FIRST MIDDLE LAST						2a. DATE KNOWN OF DEATH						2b. HOUR																																																																													
GREGORY M.						MC NEILL						DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR						8 18 1980																																																																													
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD						2d. HOUR																																																																													
male		negro		11 28 1952		27 YRS.		MONTHS DAYS HOURS MIN		8 18 1980						1:05 a.m.																																																																															
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)						7b. CITIZEN OF WHAT COUNTRY?						8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						9. BALTIMORE CITY OR COUNTY OF DEATH																																																																													
MARYLAND						U.S.A.						Prince George's Co.						MD																																																																													
10. CITY OR TOWN OF DEATH						11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						12b. KIND OF BUSINESS OR INDUSTRY																																																																													
Cheverly						Prince George's General Hospital						LABORER						CONSTRUCTION																																																																													
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13a. STATE												13b. COUNTY												13c. CITY OR TOWN												13d. INSIDE CITY LIMITS?												13e. STREET ADDRESS																																			
D.C.												NONE												WASHINGTON												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												5121 FITCH ST. S.E.																																															
14. FATHER'S NAME												15. MOTHER'S MAIDEN NAME												16a. WAS DECEASED EVER IN U.S. ARMED FORCES?												16b. SOCIAL SECURITY NO.												17. INFORMANT												ADDRESS																																			
PRESTON												McNEILL												DORA S. JOHNSON												YES												1972-1973												216-60-2951												MICHAEL McNEILL												SAME AS ITEM #13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												PART 1 DEATH WAS CAUSED BY:												IMMEDIATE CAUSE (a)												DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																															
966-												Multiple stab wounds with complications																																																																																			
																								(b)												DUE TO, OR AS A CONSEQUENCE OF																																																											
																								(c)																																																																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																																																															
19a. DATE OF OPERATION												19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?																																																																							
																								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																																																																							
21a. EXTERNAL CAUSE WAS												21b. TIME OF INJURY												21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																																																																							
UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH												10:20 P.M. 8-6-1980												Subject stabbed.																																																																							
21d. INJURY OCCURRED												21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)												21f. LOCATION																																																																							
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>												lawn												11700 blk. So. Laurel Dr. Prince George's Co. Maryland																																																																							
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>																																																																																															
ACTUAL SIGNATURE												TITLE (SPECIFY)												DATE SIGNED																																																																							
Ann M. Dixon, M.D.												Assistant												8-19-80																																																																							
EXAMINER'S NAME (TYPE OR PRINT)												ADDRESS																																																																																			
Ann M. Dixon, M.D.												111 Penn St.																																																																																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)												23b. DATE												23c. NAME OF CEMETERY OR CREMATORY												23d. LOCATION																																																											
BURIAL												8-22-1980												MT. OLIVET CEMETERY												WASHINGTON, D.C.																																																											
24. FUNERAL DIRECTOR												25a. DATE REC'D. BY REGISTRAR												25b. REGISTRAR'S SIGNATURE																																																																							
W. W. CHAMBERS CO. 517 11th ST. S.E. WASH.D.C.												AUG 25 1980																																																																																			



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DHMH - 17  
(VR A15 ME (5))  
15M/7/77

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		2b. HOUR	
THOMAS						MCNicholas		8 19 80				1:45 PM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR	
male	white	May 25, 1903		77 YRS.						8 19 80			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH					
Ireland		U.S.A.		WIDOWED		DIVORCED		Prince George's County					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		12b. KIND OF BUSINESS OR INDUSTRY							
Cheverly		Prince George's Hospital		Welder		Dept. of Navy							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland		Calvert		Chesapeake Beach		YES X NO		4010 28th Street					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
Michael		McNicholas		(unknown)									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT									
no		101-09-6558		Michael J. McNicholas									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Multiple injuries													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.													
(b)													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?					
								YES X NO					
21a. EXTERNAL CAUSE WAS				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
UNDERLYING OR CONTRIBUTING CAUSE OF DEATH				12:50 PM 8-19-80				driver of auto/auto head on impact					
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION					
WHILE AT WORK				highway				Rt. 301 350ft. N. Upper Marlboro, Maryland					
22a. I certify that I took charge of the remains described above, held on Autopsy X Inspection Inquiry and in my opinion death resulted from: Natural causes Accident X Suicide Homicide Undetermined manner													
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED					
Margarita A. Korell, M.D.				Assistant				8-20-80					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS									
Margarita A. Korell, M.D.				111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY					
Burial				8/23/80				Gate of Heaven Cem.					
23d. LOCATION (CITY OR TOWN)				COUNTY				STATE					
Silver Spring				Maryland									
24. FUNERAL HOME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
16000 Annapolis Rd., Bowie, Maryland				AUG 26 1980									

DHMH - 17  
(VR A15 ME (5))  
15M/7/77

Aug 6 1980

10000 Annapolis Rd., Bowie, Maryland  
8611 Funeral Home  
8/23/80 Date of Heaven Cem. 2 Over Spring, Maryland

Michael J. Nicholas, Jr.

Michael J. Nicholas, Jr.

10000 Annapolis Rd.

10000 Annapolis Rd.

10000 Annapolis Rd.

no ---- 101-09-6558 Michael J. Nicholas, Bowie, Md.  
16302 Pond Meadow Lane  
Michael (unknown) Lee

Maryland Calvert Chesapeake Beach x 4010 28th Street

Welder Dept. of Navy  
U.S.A. x

May 25, 1903 77

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 1 4 7 2

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>CECIL H MILLER</b>			2a DATE OF DEATH MONTH DAY YEAR <b>08 01 80</b>			2b HOUR <b>8:55P</b>			
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>8 30 08</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>71 years</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES COUNTY MD.</b>			
10 CITY OR TOWN OF DEATH <b>Laurel</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GREATER LAUREL BELTSVILLE HOSPITAL</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>forklift operator</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Pigment firm</b>	
13a STATE <b>Md</b>			13b COUNTY <b>PG</b>		13c CITY OR TOWN <b>Laurel</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>unknown</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Enona Miller</b>			13e STREET ADDRESS <b>13137 Larchdale Road</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>			16b SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <b>1944-1945</b>		17 INFORMANT <b>Loretta Miller same as above</b>		ADDRESS		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIO-RESPIRATORY FAILURE</b> <b>436 -</b> DUE TO, OR AS A CONSEQUENCE OF, (b) <b>MAJOR RIGHT HEMISPHERE STROKE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <b>HYPERTENSION, DIABETES MELLITUS</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Eleven days</b>									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from <b>7/20/80</b> , to <b>8/1/80</b> , that (I) (we) last saw the deceased alive on <b>8/1/80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <b>Abdul Nayeem</b>					DEGREE <b>M.D.</b>		22c DATE SIGNED <b>8/2/80</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>ABDUL NAYEEM</b>					22e ADDRESS <b>3450-FORT MEADE RD, LAUREL, M.D. 20810</b>				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b DATE <b>Aug. 5, 1980</b>		23c NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md</b>		
24 FUNERAL DIRECTOR <b>[Signature]</b>					25a DATE REC'D. BY REGISTRAR <b>AUG 1 1980</b>		25b REGISTRAR'S SIGNATURE <b>[Signature]</b>		

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.





MARTLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) <span style="float:right">First Middle Last</span> <span style="float:right">Mary Miller</span>			2a. DATE OF DEATH Month Day Year <span style="float:right">8 29 1980</span>			2b. HOUR M <span style="float:right">87</span>	
3. SEX <span style="float:right">Female</span>		4. RACE <span style="float:right">white</span>		5. DATE OF BIRTH <span style="float:right">12-09-07</span>		6. AGE (In years last birthday) <span style="float:right">72</span>	
7a. BIRTHPLACE (State or foreign country) <span style="float:right">Canada</span>		7b. CITIZEN OF WHAT COUNTRY? <span style="float:right">U.S.A.</span>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <span style="float:right">Prince George's Md.</span>	
10. CITY OR TOWN OF DEATH <span style="float:right">Lanham Md.</span>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <span style="float:right">Magnolia Gardens Nursing Home</span>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <span style="float:right">Dental Asst.</span>		12b. KIND OF BUSINESS OR INDUSTRY <span style="float:right">Walter Reed</span>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <span style="float:right">Washington</span>		13b. COUNTY <span style="float:right">D.C.</span>		13c. CITY OR TOWN <span style="float:right">D.C.</span>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <span style="float:right">1508 Gallatin Street</span>		14. FATHER'S NAME First Middle Last <span style="float:right">Not Known</span>		15. MOTHER'S MAIDEN NAME First Middle Last <span style="float:right">Not Known N.W.</span>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or unknown) <span style="float:right">No</span>		16b. SOCIAL SECURITY NO. <span style="float:right">578-26-8690</span>		17. INFORMANT Address <span style="float:right">Mrs. Iris T. Rache Same as No. 13</span>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <span style="float:right">Generalized arteriosclerosis with arteriosclerosis</span> <span style="float:right">4140</span> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <span style="float:right">heart &amp; kidney</span> DUE TO, OR AS A CONSEQUENCE OF (c) <span style="float:right">secondary</span>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <span style="float:right">6/13</span> , 19 <span style="float:right">80</span> , to <span style="float:right">8/29</span> , 19 <span style="float:right">80</span> , that (I) (we) last saw the deceased alive on <span style="float:right">8/29</span> , 19 <span style="float:right">80</span> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <span style="float:right">Frederick H. Wilhelm M.D.</span>		22c. DATE SIGNED <span style="float:right">8/29/80</span>		22d. PHYSICIAN'S NAME (Type) <span style="float:right">Frederick H. Wilhelm M.D.</span>		22e. ADDRESS <span style="float:right">5807 Murray Road Hyattsville</span>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <span style="float:right">Burial</span>		23b. DATE <span style="float:right">9/2/1980</span>		23c. NAME OF CEMETERY OR CREMATORY <span style="float:right">Arlington National Cemetery</span>		23d. LOCATION (City or Town) (County) (State) <span style="float:right">Arlington, Virginia</span>	
24. FUNERAL DIRECTOR <span style="float:right">Donald M. Stein Hebron Memorial F.H.</span> <span style="float:right">232 Carroll Street, N. W. Washington, D. C.</span>				25a. REC'D BY REGISTRAR DATE <span style="float:right">SEP 4 1980</span>		25b. REGISTRAR'S SIGNATURE <span style="float:right">Robert McBratney</span>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



Item 13, c G 548 10/7/80 GB

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 21474

1- STATE REGISTRAR

2a. DATE KNOWN OF DEATH ☒ MONTH ☐ DAY ☐ YEAR 8-24 1980

2b. HOUR M

3. SEX Male 4. RACE White 5. DATE OF BIRTH 12-31-38 6. AGE (IN YEARS) 41 YRS. 7. IF UNDER 1 YR. 8. IF UNDER 24 HRS. 2c. DATE PRONOUNCED DEAD 8-24 1980 2d. HOUR M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD

10. CITY OR TOWN OF DEATH (Theobalds) 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Anna Georges General Hospital 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Operating Engineer 12b. KIND OF BUSINESS OR INDUSTRY Unemployed

13a. STATE Maryland 13b. COUNTY Prince Geo. 13c. CITY OR TOWN Hyattsville 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS 5127 Flintridge Drive

14. FATHER'S NAME FIRST MIDDLE LAST Larry Miller 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Yarbrough

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes 16b. SOCIAL SECURITY NO. Vietnam 219 34 9933 17. INFORMANT ADDRESS Rosalie Miller Same as #13 (Wife)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1 DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Carbon monoxide poisoning  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.  
(b)  
DUE TO, OR AS A CONSEQUENCE OF  
(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 8-24 1980 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Self inflicted

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☒ AT WORK ☐ AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, PARK, ETC.) Street 21f. LOCATION CITY OR TOWN COUNTY STATE Cifer Ridge Recreation Center, Hyattsville, Md.

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE August P. Rodriguez M.D. Deputy MEDICAL EXAMINER DATE SIGNED 8-24-80

EXAMINER'S NAME (TYPE OR PRINT) August P. Rodriguez ADDRESS 3009 Bayburn Court, Camp Springs, Md.

23a. BURIAL, CREMATION, REMOVAL Burial 23b. DATE 8/28/80 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Md.

24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Maryland 25a. DATE REC'D. BY REGISTRAR AUG 27 1980 25b. REGISTRAR'S SIGNATURE Dorothy McCreedy

TO: Mr. MILLER

FROM: Mr. [illegible]

Subject: [illegible]

Operation: [illegible]

Reference: [illegible]

Remarks: [illegible]

Signature: [illegible]

8-11-68  
FBI  
RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80 21475 REG. NO.	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) <b>WILLIE G MILLER</b>			2a. DATE OF DEATH MONTH <b>08</b> DAY <b>23</b> YEAR <b>80</b>			2b. HOUR <b>10:25A<sub>M</sub></b>		
3 SEX <b>female</b>		4 RACE <b>negro</b>		5. DATE OF BIRTH MONTH <b>Sept.</b> DAY <b>17</b> YEAR <b>1923</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>56</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>PG</b> MD.					
10. CITY OR TOWN OF DEATH <b>CHEVERLY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>PRINCE GEORGES GENERAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Cashier</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE <b>Md</b>			13b. COUNTY <b>PG</b>			13c. CITY OR TOWN <b>Landover</b>		
14 FATHER'S NAME FIRST <b>Herbert</b> MIDDLE <b></b> LAST <b>Cousins</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Annie</b> MIDDLE <b></b> LAST <b>Alexander</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. <b>242-38-9812</b>			17 INFORMANT ADDRESS <b>John H. Miller (husband) Landover, Md</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BILATERAL BRONCHIAL PNEUMONIA</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1509 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>CARCINOMA OF ESOPHAGUS</b> (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>7-2</b> , 19 <b>80</b> , to <b>8-23</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>8/23</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) not view the body after death.											
22b. SIGNATURE <b>Joseph Colella</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>8/25/80</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOSEPH COLELLA, M.D.</b>			22e. ADDRESS <b>PRINCE GEORGES GENERAL HOSPITAL CHEVERLY</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>08/29/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Mem. Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Landover PG</b> COUNTY <b>MD</b> STATE <b>MD</b>			
24. FUNERAL DIRECTOR NAME <b>Lemuel R. Woodfork 1722 No. Capt. N.W.</b> ADDRESS						25a. DATE REC'D. BY REGISTRAR <b>SEP 2 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Ruby McBrady</b>			



538-RE-245

20

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 2 1 4 7 6			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
ROBERT LAURIE MITCHELL JR								AUGUST 4 1980					1051A M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
MALE		WHITE		JANUARY 30 1923		57 YRS		MONTHS		DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
DIST OF COLUM		USA				PRINCE GEORGES COUNTY MD							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
ANDREWS AFB		MALCOLM GROW USAF MED CENTER		ATTORNEY		of Law							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
MARYLAND		CHARLES		LAPLATA		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		BOX 966 OAK GROVE					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST			
ROBERT		LAURIE		MITCHELL		CATHERINE		MAUDE		DIGGES			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
YES				1942-1970		218-09-7140		ROBERT L. MITCHELL III, RT 1, BOX 81B CHARLOTTE HALL					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIOVASCULAR COLLAPSE PROBABLY DUE TO</u> <u>1629</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>SEPSIS</u> <u>SQUAMOUS CELL CANCER OF THE LUNG</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>3 MONTHS</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>3 MONTHS</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22. I certify that (I) (this hospital) attended the deceased from <u>3 AUG 80</u> , 19 <u>80</u> , to <u>4 AUG</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>4 AUG</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Luckey M. Dunn</u>				DEGREE <u>MD</u>				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22i. DATE SIGNED <u>1145 4 AUG 80</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS							
LUCKEY M. DUNN, CAPT, USAF, MC MG USAF MC ANDREWS AFB, MD 20331													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
Burial		8/6/1980		Mount Rest Cemetery		La Plata, Charles, Md.							
24. FUNERAL DIRECTOR NAME						ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Arehart Funeral Home, Inc.-La Plata, Md.								AUG 13 1980		<u>[Signature]</u>			

BP

DHMM-16 25M  
(VRA 15, 4) 1/79



Medical Examiner notified & released body.  
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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BP

DHMH - 16 50M 7/77  
(VRA 15 (4))
 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

8021477

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Ernst Carl Moh			2a. DATE OF DEATH MONTH DAY YEAR 8-29-80			2b. HOUR 5:40 a.m.			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Apr. 14, 1904		6 AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD.			
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pipefitter		12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. STATE Florida			13b. COUNTY Lee		13c. CITY OR TOWN N. Ft. Myers		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Reinhold Moh			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Christine Muller			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 145-12-8823A			17. INFORMANT Edwin Moh, Same as # 13						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u> 431- DUE TO, OR AS A CONSEQUENCE OF (b) <u>MASSIVE CEREBRAL HEMORRHAGE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>HYPERENSION - ARTERIOSCLEROSIS</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 8-28-80, 1980, to 8-28-80, 1980, that (I) (we) last saw the deceased alive on 8-28-80, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Danilo Lee MD			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-29-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANILLO LEE			22e. ADDRESS 6192 OXON HILL RD OXON HILL MD 20021						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 9-2-80		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crem.		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Va.		
24. FUNERAL DIRECTOR NAME Huntt Funeral Home, Waldorf, Maryland			ADDRESS		25a. DATE RECD. BY REGISTRAR SEP 8 1980		25b. REGISTRAR'S SIGNATURE		



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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

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REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MARIE ELLIAN MOORE			2a. DATE OF DEATH MONTH DAY YEAR 08 08 80			2b. HOUR P 8:00 M	
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 6-26-1903		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.	
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland				13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Brandywine	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS 14307 Springfield Rd.			
14. FATHER'S NAME FIRST MIDDLE LAST Robert Burroughs				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora Neal			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-52-7664		17. INFORMANT ADDRESS 506 Clova Ave. Cpt. Heights Md. 2002			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Strokes 436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Seizures (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). Sepsis from Decubitus Ulcers							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7/16, 19 80, to 8/12, 19 80, that (we) lost saw the deceased alive on 8/8, 19 80, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
22b. SIGNATURE Frederick Cantor		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/9	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FREDERICK CANTOR, M.D.		22e. ADDRESS 9811 MALLARD D, LAUREL MD 20811					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/13/1980		23c. NAME OF CEMETERY OR CREMATORY Ausbury Ch. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Brandywine, Md. P.G. Co.	
24. FUNERAL DIRECTOR NAME Martell Adams		ADDRESS Crownsville, Md.		25a. DATE REC'D. BY REGISTRAR AUG 12 1980		25b. REGISTRAR'S SIGNATURE P. J. Kennedy	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





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OFFICE OF THE COUNTY

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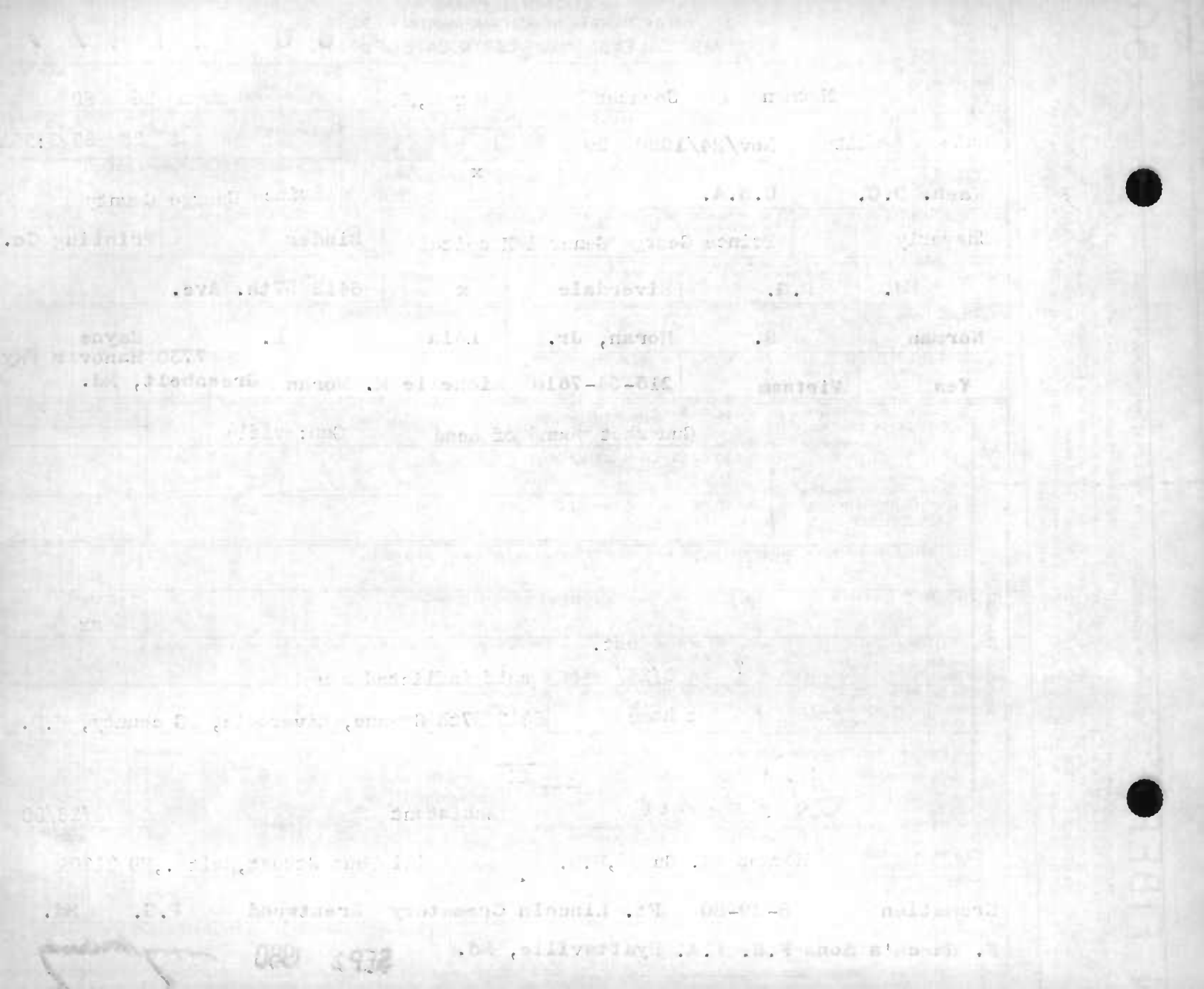
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST <b>Norman</b>			MIDDLE <b>Spencer</b>			LAST <b>Moran, JR</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 8 26 19 80			2b. HOUR M				
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov/24/1950</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) <b>29</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>8 28 19 80</b>			7d. HOUR M <b>3:56A</b>				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash. D.C.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George County</b> MD.							
10. CITY OR TOWN OF DEATH <b>Cheverly</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Prince George General Hospital</b>								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Binder</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Printing Co.</b>			
13a. STATE <b>Md.</b>				13b. COUNTY <b>P.G.</b>				13c. CITY OR TOWN <b>Riverdale</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS <b>6412 57th. Ave.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Norman S. Moran, Jr.</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lala L. Hayne</b>						17. INFORMANT ADDRESS <b>7730 Hanover Pky</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				(IF YES, GIVE WAR OR DATES) <b>Vietnam</b>				16b. SOCIAL SECURITY NO. <b>215-54-7618</b>				17. INFORMANT <b>Michelle M. Moran</b>				ADDRESS <b>Greenbelt, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gun shot wound of head</b> Gun: rifle Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY <b>est.</b> HOUR A.M. MONTH DAY YEAR <b>? P.M. 8/26/ 19 80</b>						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>self inflicted wound</b>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>at home</b>						21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>6412 57th Avenue, Riverdale, PG county, M.D.</b>							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>gunshot wound</b> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE <b>Hormez R. Guard</b>						TITLE (SPECIFY) <b>Assistant</b>						DATE SIGNED <b>8/28/80</b>							
EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>						ADDRESS <b>111 Penn Street, Balto., MD 21201</b>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>						23b. DATE <b>8-29-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crematory</b>						23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood P.G. Md.</b>					
24. FUNERAL DIRECTOR <b>F. Gasch's Sons F.H. P.A. Hyattsville, Md.</b>												25a. DATE REC'D. BY REGISTRAR <b>SEP 2 1980</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 1 4 8 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELIZABETH M. MUCKELBAUER			2a. DATE OF DEATH MONTH DAY YEAR 08-21-80			2b. HOUR 10:55 PM				
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Mar. 15 1908		6. AGE (IN YEARS LAST BIRTHDAY) 72		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D. C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.				
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Typist		12b. KIND OF BUSINESS OR INDUSTRY Private Self-Employed		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7107 Wells Parkway	
14. FATHER'S NAME FIRST MIDDLE LAST Frank G. Muckelbauer			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosa D. Speckert							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATE) 578-62-8480		17. INFORMANT Sister Catherine M. McCarthy same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Disease 486- Conditions, if any, which gave rise to immediate cause (b) Septicemic Shock DUE TO: OR AS A CONSEQUENCE OF underlying cause last. (c) Pneumonia, bsp. Failure DUE TO: OR AS A CONSEQUENCE OF										
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8/20, 19 80, to 8/21, 19 80, that (I) (we) lost saw the deceased alive on 8/21, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE DEGREE JOSEPH COLELLA, M.D.			22c. ADDRESS PGGH/MC CHEVERLY, MD 20785			22d. DATE SIGNED 8/22/80				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Aug. 25, 1980		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md.			
24. FUNERAL DIRECTOR NAME Francis J. Collins			25a. DATE REC'D. BY REGISTRAR AUG 26 1980			25b. REGISTRAR'S SIGNATURE R. J. H. H. H.				
500 University Blvd., W. Silver Spring, Md.										

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 2 1 4 8 1			
1. FOR STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Blanche A. MULLOY						2a. DATE OF DEATH MONTH DAY YEAR August 8, 1980				2b. HOUR 6:46p.M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 2, 1892		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) District of Columbia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince-Georges MD.							
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Government Clerk			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE District of Columbia				13b. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1709 Hobart Street, N.W.					
14. FATHER'S NAME FIRST MIDDLE LAST John Barker				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia West									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 579-60-6938		17. INFORMANT ADDRESS Margaret A. Berckmann 3639 Highwood Dr. S.E. Wash. D.C.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Pulmonary Edema</i> 9000 } DUE TO, OR AS A CONSEQUENCE OF (b) <i>Heart Stroke</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerotic heart disease</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 3 days 5 years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 8-8-80, 1980, to 8-8-80, 1980, that (I) (we) last saw the deceased alive on 8-8-80, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Thomas F. Collins						DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-8-80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS F. COLLINS M.D.						22e. ADDRESS 2600 Green Chapel Rd							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 8-12-1980		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C.					
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Maryland						25a. DATE REC'D. BY REGISTRAR AUG 14 1980		25b. REGISTRAR'S SIGNATURE R. J. McCreedy					

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

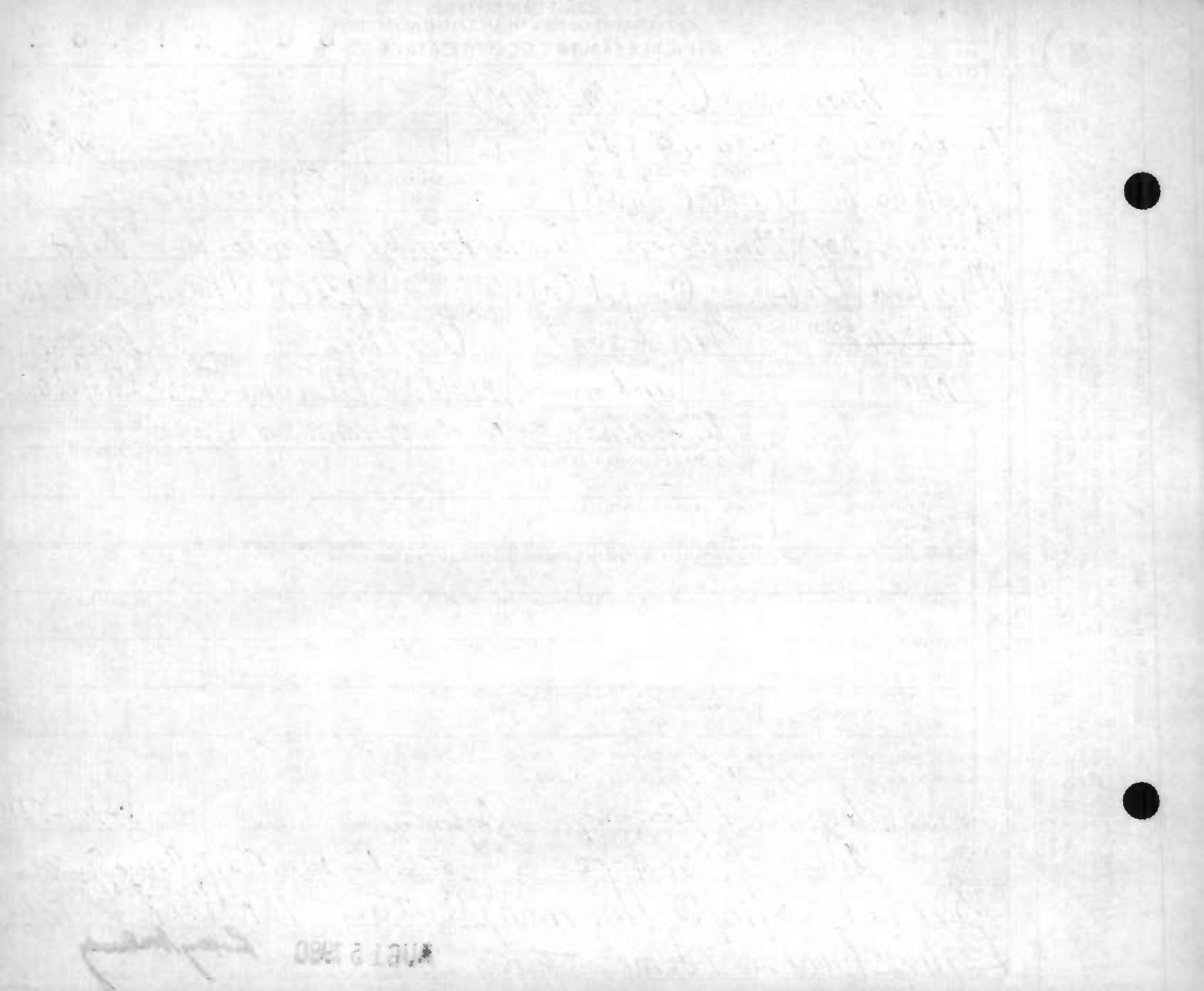
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1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Marie C. MURPHY</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 8-10 1980			2b. HOUR 6A		
3. SEX <b>Female</b>			4. RACE <b>Black</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>7-14-1961</b>		
6. AGE (IN YEARS) LAST BIRTHDAY <b>61</b> YRS.			7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.			8. IF UNDER 24 HRS.		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Charlotte NC</b>			10. CITIZEN OF WHAT COUNTRY? <b>United States</b>			11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
12. CITY OR TOWN OF DEATH <b>Chesapeake</b>			13. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION <b>Prince Georges General Hospital</b>			14. USUAL OCCUPATION (TYPE OF WORK OR WORKING LIFE) <b>Housewife</b>		
15. USUAL RESIDENCE (GIVE STREET ADDRESS) <b>Maryland P.O. Chapel Oaks</b>			16. CITY OR TOWN <b>Chapel Oaks</b>			17. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
18. STREET ADDRESS <b>1208 Chapel Oaks Dr</b>			19. FATHER'S NAME FIRST MIDDLE LAST <b>John Jackson</b>			20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Willie Johnson</b>		
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>			22. SOCIAL SECURITY NO. <b>577-40-0464</b>			23. INFORMANT <b>Mildred Murphy - 1208 Chapel Oaks</b>		
24. ADDRESS <b>Dr. Chapel Oaks</b>			25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. <b>4029</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
26a. DATE OF OPERATION			26b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			27. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
28a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			28b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			28c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
29a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			29b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			29c. LOCATION STREET CITY OR TOWN COUNTY STATE		
29d. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
30. ACTUAL SIGNATURE <b>August P. Rodriguez</b>			31. TITLE (SPECIFY) <b>Detective</b>			32. MEDICAL EXAMINER DATE SIGNED <b>8-10-80</b>		
33. EXAMINER'S NAME (TYPE OR PRINT) <b>August P Rodriguez</b>			34. ADDRESS <b>5009 Rappahannock Camp Springs</b>			35. DATE REC'D. BY REGISTRAR <b>AUG 15 1980</b>		
36. REGISTRAR'S SIGNATURE <b>Harry H. H. H.</b>			37. DATE <b>8-10-80</b>			38. LOCATION CITY OR TOWN COUNTY STATE <b>Landover Md</b>		
39. FUNERAL DIRECTOR NAME ADDRESS <b>Collins Funeral Home, Inc.</b>			40. DATE <b>8/15/80</b>			41. NAME OF CEMETERY OR CREMATOR <b>Harmony Cemetery</b>		
42. FUNERAL CREMATION/REMOVAL <b>Burial</b>			43. DATE <b>8/15/80</b>			44. NAME OF CEMETERY OR CREMATOR <b>Harmony Cemetery</b>		
45. FUNERAL DIRECTOR NAME ADDRESS <b>Collins Funeral Home, Inc.</b>			46. DATE <b>8/15/80</b>			47. NAME OF CEMETERY OR CREMATOR <b>Harmony Cemetery</b>		

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



APR 2 1960

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 2 1 4 8 3	
1. FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
MYRTLE H. MURPHY						8-13-80			3:20 P		
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Female		White		June 27 1895		85 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.					
Canada		U. S. A.									
10 CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors Hospital of Prince George				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY At Home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN White Plains		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Rt. #1 Box 428			
14. FATHER'S NAME FIRST MIDDLE LAST Robert Barrett				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown Owens							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF NOT IN U.S. ARMY OR NAVAL RESERVE) None		17. INFORMANT ADDRESS Md Etta Klink 303 1st Ave. Washington Grove					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Cardiovascular disease</u> Approximate interval between onset and death: <u>Weeks</u> <u>months</u> <u>years</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Cerebrovascular accident</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <u>7-19</u> 19 <u>80</u> , to <u>8-13</u> 19 <u>80</u> , that (1) (we) lost saw the deceased alive on <u>8-13</u> 19 <u>80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>James J. Kim, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8-14-80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James J. Kim				22e. ADDRESS 10694 Campus Way S., Largo, Md. 20870							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/16/80		23c. NAME OF CEMETERY OR CREMATORY Rose Hills Cemetery Oxon Hill			23d. LOCATION CITY OR TOWN COUNTY STATE Whittier Los Angeles Calif.			
24. FUNERAL DIRECTOR NAME ADDRESS George P Kalas F. H. 6160 Oxon Hill Rd Maryland											

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Doctors Hospital of Prince George's County

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Dr. F. V. B.

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George &amp; Helen T. H. (1860-1911)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	0	2	1	4	8	4
1- FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elizabeth F. Murto										2a. DATE OF DEATH MONTH DAY YEAR 8-30-1980				2b. HOUR 9:17A M		
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR February 9 1892			6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.							
10. CITY OR TOWN OF DEATH Hyattsville			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Home						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN New Jersey Mercer Trenton										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 447 Bellevue Ave				
14. FATHER'S NAME FIRST MIDDLE LAST Frank E. Ferguson						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Garrity										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 150-36-6684			17. INFORMANT ADDRESS Dr. Robert Murto Washington Crossing, PA Dunkin Drive										
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE C</u> <u>2500</u> DUE TO <u>CONGESTIVE HEART FAILURE</u> (b) <u>DIABETES MELLITUS</u> DUE TO, OR AS A CONSEQUENCE OF <u>PARKINSON SYNDROME</u> (c) <u>4 years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>4 years</u> <u>4 years</u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.																
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>DEC 6</u> , 19 <u>76</u> , to <u>AUG 30</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>8-23</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE Thomas F Collins						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8-30-80				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS F COLLINS MD						22e. ADDRESS 2600 QUEEN'S CHAPEL RD										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Sept 4, 1980		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia						
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Homes, P.A. Bethesda, Maryland						25a. DATE REC'D. BY REGISTRAR SEP 8 1980				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>						

MEDICAL CERTIFICATION



1917	1918	1919	1920	1921	1922	1923	1924	1925	1926	1927	1928	1929	1930	1931	1932	1933	1934	1935	1936	1937	1938	1939	1940	1941	1942	1943	1944	1945	1946	1947	1948	1949	1950	1951	1952	1953	1954	1955	1956	1957	1958	1959	1960	1961	1962	1963	1964	1965	1966	1967	1968	1969	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044	2045	2046	2047	2048	2049	2050	2051	2052	2053	2054	2055	2056	2057	2058	2059	2060	2061	2062	2063	2064	2065	2066	2067	2068	2069	2070	2071	2072	2073	2074	2075	2076	2077	2078	2079	2080	2081	2082	2083	2084	2085	2086	2087	2088	2089	2090	2091	2092	2093	2094	2095	2096	2097	2098	2099	2100	2101	2102	2103	2104	2105	2106	2107	2108	2109	2110	2111	2112	2113	2114	2115	2116	2117	2118	2119	2120	2121	2122	2123	2124	2125	2126	2127	2128	2129	2130	2131	2132	2133	2134	2135	2136	2137	2138	2139	2140	2141	2142	2143	2144	2145	2146	2147	2148	2149	2150	2151	2152	2153	2154	2155	2156	2157	2158	2159	2160	2161	2162	2163	2164	2165	2166	2167	2168	2169	2170	2171	2172	2173	2174	2175	2176	2177	2178	2179	2180	2181	2182	2183	2184	2185	2186	2187	2188	2189	2190	2191	2192	2193	2194	2195	2196	2197	2198	2199	2200	2201	2202	2203	2204	2205	2206	2207	2208	2209	2210	2211	2212	2213	2214	2215	2216	2217	2218	2219	2220	2221	2222	2223	2224	2225	2226	2227	2228	2229	2230	2231	2232	2233	2234	2235	2236	2237	2238	2239	2240	2241	2242	2243	2244	2245	2246	2247	2248	2249	2250	2251	2252	2253	2254	2255	2256	2257	2258	2259	2260	2261	2262	2263	2264	2265	2266	2267	2268	2269	2270	2271	2272	2273	2274	2275	2276	2277	2278	2279	2280	2281	2282	2283	2284	2285	2286	2287	2288	2289	2290	2291	2292	2293	2294	2295	2296	2297	2298	2299	2300	2301	2302	2303	2304	2305	2306	2307	2308	2309	2310	2311	2312	2313	2314	2315	2316	2317	2318	2319	2320	2321	2322	2323	2324	2325	2326	2327	2328	2329	2330	2331	2332	2333	2334	2335	2336	2337	2338	2339	2340	2341	2342	2343	2344	2345	2346	2347	2348	2349	2350	2351	2352	2353	2354	2355	2356	2357	2358	2359	2360	2361	2362	2363	2364	2365	2366	2367	2368	2369	2370	2371	2372	2373	2374	2375	2376	2377	2378	2379	2380	2381	2382	2383	2384	2385	2386	2387	2388	2389	2390	2391	2392	2393	2394	2395	2396	2397	2398	2399	2400	2401	2402	2403	2404	2405	2406	2407	2408	2409	2410	2411	2412	2413	2414	2415	2416	2417	2418	2419	2420	2421	2422	2423	2424	2425	2426	2427	2428	2429	2430	2431	2432	2433	2434	2435	2436	2437	2438	2439	2440	2441	2442	2443	2444	2445	2446	2447	2448	2449	2450	2451	2452	2453	2454	2455	2456	2457	2458	2459	2460	2461	2462	2463	2464	2465	2466	2467	2468	2469	2470	2471	2472	2473	2474	2475	2476	2477	2478	2479	2480	2481	2482	2483	2484	2485	2486	2487	2488	2489	2490	2491	2492	2493	2494	2495	2496	2497	2498	2499	2500	2501	2502	2503	2504	2505	2506	2507	2508	2509	2510	2511	2512	2513	2514	2515	2516	2517	2518	2519	2520	2521	2522	2523	2524	2525	2526	2527	2528	2529	2530	2531	2532	2533	2534	2535	2536	2537	2538	2539	2540	2541	2542	2543	2544	2545	2546	2547	2548	2549	2550	2551	2552	2553	2554	2555	2556	2557	2558	2559	2560	2561	2562	2563	2564	2565	2566	2567	2568	2569	2570	2571	2572	2573	2574	2575	2576	2577	2578	2579	2580	2581	2582	2583	2584	2585	2586	2587	2588	2589	2590	2591	2592	2593	2594	2595	2596	2597	2598	2599	2600	2601	2602	2603	2604	2605	2606	2607	2608	2609	2610	2611	2612	2613	2614	2615	2616	2617	2618	2619	2620	2621	2622	2623	2624	2625	2626	2627	2628	2629	2630	2631	2632	2633	2634	2635	2636	2637	2638	2639	2640	2641	2642	2643	2644	2645	2646	2647	2648	2649	2650	2651	2652	2653	2654	2655	2656	2657	2658	2659	2660	2661	2662	2663	2664	2665	2666	2667	2668	2669	2670	2671	2672	2673	2674	2675	2676	2677	2678	2679	2680	2681	2682	2683	2684	2685	2686	2687	2688	2689	2690	2691	2692	2693	2694	2695	2696	2697	2698	2699	2700	2701	2702	2703	2704	2705	2706	2707	2708	2709	2710	2711	2712	2713	2714	2715	2716	2717	2718	2719	2720	2721	2722	2723	2724	2725	2726	2727	2728	2729	2730	2731	2732	2733	2734	2735	2736	2737	2738	2739	2740	2741	2742	2743	2744	2745	2746	2747	2748	2749	2750	2751	2752	2753	2754	2755	2756	2757	2758	2759	2760	2761	2762	2763	2764	2765	2766	2767	2768	2769	2770	2771	2772	2773	2774	2775	2776	2777	2778	2779	2780	2781	2782	2783	2784	2785	2786	2787	2788	2789	2790	2791	2792	2793	2794	2795	2796	2797	2798	2799	2800	2801	2802	2803	2804	2805	2806	2807	2808	2809	2810	2811	2812	2813	2814	2815	2816	2817	2818	2819	2820	2821	2822	2823	2824	2825	2826	2827	2828	2829	2830	2831	2832	2833	2834	2835	2836	2837	2838	2839	2840	2841	2842	2843	2844	2845	2846	2847	2848	2849	2850	2851	2852	2853	2854	2855	2856	2857	2858	2859	2860	2861	2862	2863	2864	2865	2866	2867	2868	2869	2870	2871	2872	2873	2874	2875	2876	2877	2878	2879	2880	2881	2882	2883	2884	2885	2886	2887	2888	2889	2890	2891	2892	2893	2894	2895	2896	2897	2898	2899	2900	2901	2902	2903	2904	2905	2906	2907	2908	2909	2910	2911	2912	2913	2914	2915	2916	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FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

8 0 2 1 4 8 5

1. DECEASED NAME (TYPE OR PRINT)		FIRST Virginia		MIDDLE Shaper		LAST NORTHINGTON		2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH		DAY		YEAR		2b. HOUR			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9-15-98		6. AGE (IN YEARS) LAST BIRTHDAY 81 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD		8-17		1980		7a. HOUR 730			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.													
10. CITY OR TOWN OF DEATH Greenbelt		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greenbelt Conv. Center						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY Own Home							
13a. STATE Maryland		13b. COUNTY Prince Georges		13c. CITY OR TOWN Landover Hills		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7426 Parkwood Street											
14. FATHER'S NAME John T. Shaper				15. MOTHER'S MAIDEN NAME Mary Renneberger															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 230 28 0648				17. INFORMANT ARTHUR H. Northington Summer #13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetic arterio-sclerotic cardiac vascular disease</u> 2507 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE Augusto P. Rodriguez				TITLE (SPECIFY) Deputy				MEDICAL EXAMINER				DATE SIGNED 8-17-80							
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez M.D.				ADDRESS 5009 Rayburn Ct., Camp Springs, Md.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 8/21/80				23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Md.							
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Maryland										25a. DATE REC'D. BY REGISTRAR AUG 20 1980				25b. REGISTERED P.G. Md.					

MEDICAL CERTIFICATION

2

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE FUNERAL DIRECTOR. GIVE PAGE 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

• • •

240 82 050

A.C.J.

Items #10a-22a Film G548 10/21/80 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
1- STATE REGISTRAR rc MEDICAL EXAMINER'S CERTIFICATE OF DEATH 3 0 2 1 4 8 6 REG. NO.

1. DECEASED NAME FIRST MIDDLE LAST  
Oswalo Chaves Oliveira-Filho

2a. DATE KNOWN OF DEATH MONTH DAY YEAR 8 17 19 80  
2b. DATE PRONOUNCED DEAD MONTH DAY YEAR 8 17 19 80  
2d. HOUR M 1:45A M

3. SEX Male 4. RACE Black 5. DATE OF BIRTH MONTH DAY YEAR Aug. 22, 1944 35 YRS.  
6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Brazil 7b. CITIZEN OF WHAT COUNTRY? Brazil  
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD

10. CITY OR TOWN OF DEATH Riversides 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital  
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Servant 12b. KIND OF BUSINESS OR INDUSTRY Brazilian Air Force

13a. STATE Maryland 13b. COUNTY Prince Georges 13c. CITY OR TOWN Hyattsville  
13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS 2725 Nicholson Street

14. FATHER'S NAME FIRST MIDDLE LAST Oswalo Chaves Oliveira  
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Salustiana S. de Oliveira

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no (IF YES, GIVE WAR OR DATES) -----  
16b. SOCIAL SECURITY NO. 214-92-3733  
17. INFORMANT Sonildis A. Oliveira 2725 Nicholson Street Hyattsville, Maryland

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1 DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Cardiac failure  
4289  
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.  
(b) \_\_\_\_\_  
(c) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF  
DUE TO, OR AS A CONSEQUENCE OF

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH  
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  
21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK  
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  
21f. LOCATION CITY OR TOWN COUNTY STATE

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE TITLE (SPECIFY) DATE SIGNED 8/18/80  
Assistant MEDICAL EXAMINER  
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. ADDRESS 111 Penn St. Balto., MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE Aug. 20, 1980 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery 23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D. C.

24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave., N. W., Wash., D. C. 200  
25a. DATE REC'D. BY REGISTRAR AUG 22 1980 REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 7 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A13 ME (3))  
15M 7/76

(M)

1980

1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					8 0 2 1 4 8 7 REG. NO.					
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>William Patten</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>8-17-80</i>					2b. HOUR <i>5:40 PM</i>
3 SEX <i>Male</i>		4 RACE <i>Black</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>5/18-10</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>70</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>PRINCE GEORGES COUNTY MD.</i>				
10 CITY OR TOWN OF DEATH <i>Laurel</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>GREATER LAUREL BELTSVILLE HOSPITAL</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Gov't.</i>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE <i>Md.</i>		13b. COUNTY <i>P.G.</i>		13c. CITY OR TOWN <i>Bowie</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>12006 Duckettown Rd.</i>		
14 FATHER'S NAME FIRST MIDDLE LAST <i>William Patten, Sr.</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Lillie S. Randall</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>None</i>		17 INFORMANT ADDRESS <i>Sterling Patten-Same as # 13 above</i>						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Respiratory Failure</i>										
DO TO, OR AS A CONSEQUENCE OF <i>Passive Pulmonary Embolism</i>										
DO TO, OR AS A CONSEQUENCE OF <i>Carcinoma Right Lung</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE OF DEATH (List in item 18, PART 1 (a)) <i>Malnutrition, Anemia, Hypocalcemia</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		20f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <i>Aug 11</i> 19 <i>80</i> , to <i>Aug 17</i> 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>Aug 17</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Gursewa S. Pabla md.</i>					DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>8-17-80</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>GURSEWA S. PABLA MD</i>					22e. ADDRESS <i>704 GORMAN AVE Smt 4. LAUREL, Md - 20854</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>8-23-1980</i>		23c. NAME OF CEMETERY OR CREMATORY <i>MT. ZION CH. CEM.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>LAUREL MD</i>				
24 FUNERAL DIRECTOR NAME <i>H. S. WASHINGTON + SONS</i>					ADDRESS <i>4925 BURKHOUS AVE</i>		25a. DATE REC'D. BY REGISTRAR <i>AUG 27 1980</i>		25b. REGISTRAR'S SIGNATURE <i>Dorothy McCreedy</i>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8021488			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Hilda H		PAYNE						August 31, 1980					11:45p.
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Female		white		Feb., 23, 1900		80		Muncney, Pa.		USA			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		9. BALTIMORE CITY OR COUNTY OF DEATH					
Lanham		Dr.'s Hospital of Pr. Geo. Co.		Housewife		Home		Prince George's County					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Md. 20801		P.G.		Lanham		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6104 Seabrook Road					
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
Edward Frey		Mary											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT									
No		None		579-26-9992		Lanham, Md. 20801		B Clark M. Payne-husband		6104 Seabrook Rd.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Melastosis</u> 1840 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Chronicism of Vagina</u> (c) <u></u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
		HOUR A.M. MONTH DAY YEAR											
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION									
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED							
Benjamin S. Pecson, M.D.						20028							
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION							
Cremation		9-1-80		Lee's Crematory		Washington, D.C.		COUNTY		20002		STATE	
24 FUNERAL DIRECTOR		25. DATE REC'D. BY REGISTRAR		26. SIGNATURE									
Lee Funeral Home		300-4th St. N.E.		Wash. D.C. 20002		SEP 4 1980							



and

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR FOR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE																																							
1- STATE REGISTRAR										MEDICAL EXAMINER'S CERTIFICATE OF DEATH																																							
1. DECEASED NAME (TYPE OR PRINT)					FIRST MIDDLE LAST					2a. DATE KNOWN OF DEATH					2b. HOUR																																		
MARY ELLEN PEED										AUG 28 1980					1:10 PM																																		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD					2d. HOUR																																
F		White		10 18 86		93 YRS.		MONTHS DAYS		HOURS MIN.		8-28 1980					1:10 PM																																
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH																																		
Md.					U.S.A.										PRINCE GEORGE'S CTY. MD.																																		
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY																																		
RIVERDALE MD. 20840					LELAND MEMORIAL HOSPITAL					Housewife																																							
13a. STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET ADDRESS									
MD.										PRINCE GEORGE'S										HYATTSVILLE										YES										5900-JAMESTOWN RD.									
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)					16b. SOCIAL SECURITY NO.					17. INFORMANT					ADDRESS																								
RICHARD O.					Barbara A. Brookbank					No					227-07-6991D					Margaret L. Barbour					Same as above																								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
PART 1 DEATH WAS CAUSED BY:																																																	
IMMEDIATE CAUSE: <i>Ischemic heart disease</i>																																																	
4292																																																	
DUE TO, OR AS A CONSEQUENCE OF																																																	
(b)																																																	
DUE TO, OR AS A CONSEQUENCE OF																																																	
(c)																																																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																	
<i>Left femoral fracture, breast neoplasm, blood urea, pneumonia, spec. infections.</i>																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?																													
8/23/80										<i>Left femoral fracture</i>										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																													
										(PM) 8/22 19 80										<i>Proximal pathologic fracture</i>																													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK										21e. PLACE OF INJURY (ATHOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION																													
										<i>Nursing home</i>										<i>5801 42nd Avenue Hyattsville, Md</i>																													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																																																	
ACTUAL SIGNATURE										TITLE (SPECIFY)										DATE SIGNED																													
<i>Augusto P. Rodriguez</i>										M.D. Deputy										8/28/80																													
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS																																							
Augusto P. Rodriguez M.D.										5009 Rayburn Ct., Camp Springs, Md.																																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION																			
Burial										8-30-80										Cedar Hill Cem.										Suitland Pr. Geo. Md.																			
24. FUNERAL DIRECTOR										25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																													
Nalley's F.H. Inc. Mt. Rainier, Md.										SEP 2 1980										<i>Augusto P. Rodriguez</i>																													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
8 0 2 1 4 9 0										
REG. NO.										
1. DECEASED NAME (TYPE OR PRINT) Agustina Maria Perez					2a. DATE OF DEATH MONTH DAY YEAR 8-29-80					2b. HOUR 1A M
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 26, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SPAIN		7b. CITIZEN OF WHAT COUNTRY? Legal Resident		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.				
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MANOR Care Hyattsville				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Beltsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3201 Beltsville Road 20705		
14. FATHER'S NAME FIRST MIDDLE LAST Manuel Gonzalez					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Manuela Garcia					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT Lilian Ceballos		ADDRESS Same As Item #13			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary vascular accident 10 years gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Embolism all four limbs										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 12/7/75 to 8/29/80, that (I) (we) lost saw the deceased alive on 8/20/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death										
22b. SIGNATURE J. M. Kualan					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/29/80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) IBRAHIM. M. KHATRI					22e. ADDRESS 6525 Belcrest Road Hyattsville MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/02/80		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Mont. Md.			
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home					ADDRESS 11800 N.H. Ave. Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR SEP 2 1980		25b. REGISTRAR'S SIGNATURE [Signature]	

BP



U.S. AIR FORCE



259 932

STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

21491

 FOR  
 STATE  
 REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTIMATED		MONTH		DAY		YEAR		2b. HOUR	
Amy Irene		PHILLIPS						8-9		1980									
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
Female	White	10-16-23		56 YRS.						8-9		1980						9:55	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH							
WEST VIRGINIA		U.S.A.										Prince Georges							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
CHEVERLY		PRINCE GEORGES GENERAL HOSPITAL		FISCAL CLERK		U.S. TARIFF COM													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
MARYLAND		PRINCE GEO.		W. HYATTSVILLE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2007 PATTERSON ROAD											
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST									
HARRY		WALTER		SHAFFER		ERSIE		NESTOR											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
NO		236-32-6971		CLARENCE CECIL PHILLIPS		SAME AS 13													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
5715		Hepatic cirrhosis																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF															
		(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held on death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion															
ACTUAL SIGNATURE		DEPUTY		DATE SIGNED		8-10-80													
EXAMINER'S NAME (TYPE OR PRINT)		AUGUSTO P. RODRIGUEZ, M.D.		5009 RAYBURN CT., CAMP SPRINGS, MD															
23a. BURIAL, CREMATION, OR OTHER		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE													
BURIAL		8/13/80		PARKLAWN CEMETERY		ROCKVILLE MONT MD.													
24. FUNERAL DIRECTOR NAME		FRANCIS J. COLLINS		500 UNIV. BLVD., W., SILVER SPRING, MD. 20901		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
						AUG 14 1980		[Signature]											

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD WRITE "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

19412

19412



19412

19412

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. YOUR FILES TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M7/77

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21492	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>STERLING W. POWELL</b>										2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR HOUR <b>8 15 19 80</b>	
3. SEX <b>male</b>		4. RACE <b>black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 25 53</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>27 YRS.</b>		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>8 19 80</b>		7b. HOUR <b>11:00</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County</b>	
10. CITY OR TOWN OF DEATH <b>Suitland Pkwy.</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION <b>Suitland Pkwy. Maylor Rd.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Dept. of Treasury</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov.</b>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>D. C.</b>		13b. COUNTY		13c. CITY OR TOWN <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2804 Buena Vista Terrace, S.E.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>William H. Powell</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marion Crawford</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>578-66-3727</b>		17. INFORMANT ADDRESS <b>Mrs. Marion Powell/mother/1947 Valley Ter. S. E., Wash., D. C.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>7999</b> IMMEDIATE CAUSE (a) <b>Undetermined</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that I took charge of the remains described above, held an <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> .											
ACTUAL SIGNATURE <b>Margarita A. Korell</b>						TITLE (SPECIFY) <b>Assistant</b>		MEDICAL EXAMINER		DATE SIGNED <b>8-20-80</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>										ADDRESS <b>111 Penn Street</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>8-26-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Memorial Park</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Landover, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>John T. Rhines Co., 3015 12th St., N.E., D.C. 20017</b>						25a. DATE RECEIVED BY REGISTRAR <b>SEP 2 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



01-03-0

Shedding

Shedding

Shedding

SEP 1938

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (5))  
15M7/77

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3021493	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Robert Emerson Prentice</b>										20. DATE OF DEATH ESTIMATED MONTH DAY YEAR <b>8 6 19 80</b>		21. HOUR M <b>1:35 PM</b>									
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept 7, 1918</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) <b>61 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN. <b>0 0 0 0</b>		IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>		22. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>8 6 19 80</b>		23. HOUR M <b>1:35 PM</b>							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Colorado</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George County</b>									
10. CITY OR TOWN OF DEATH <b>Cheverly</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Prince George General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Merchant Marine</b>				12b. KIND OF BUSINESS OR INDUSTRY									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Florida</b>										13b. COUNTY <b>Hillsborough</b>		13c. CITY OR TOWN <b>Tampa</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>210 West Genesee Street</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert Dennis Prentice</b>										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ellen Estelle Potts</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>WWII</b>				17. INFORMANT <b>Robert W. Prentice</b>				ADDRESS <b>3804 Ridge Rd Annandale, VA.</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple injuries</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>8:45 PM 8/5 19 80</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>driver of auto struck by pickup truck</b>													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>roadway</b>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Rt #231, Patuxent River Bridge, Prince Frederick, Maryland</b>													
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE <b>Hormez R. Guard, M.D.</b>				TITLE (SPECIFY) <b>Assistant</b>				MEDICAL EXAMINER <b>111 Penn Street, Balto., MD 21201</b>				DATE SIGNED <b>8/7/80</b>									
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>				23b. DATE <b>11 Aug 80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland PG Md</b>											
24. FUNERAL DIRECTOR NAME <b>Robert E. Wilhelm</b>										25a. DATE REC'D. BY REGISTRAR <b>AUG 15 1980</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>									
Funeral Home Inc										Suitland, Md											



17812 1000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE RETURNED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21494					
1. DECEASED NAME (TYPE OR PRINT) <i>Gregory C. PRICE</i>										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 8-11 1980										2b. HOUR M 8:00 P 8:00					
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>8-22-54</i>		6. AGE (IN YEARS) (LAST BIRTHDAY) <i>25</i> YRS		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>8-11 1980</i>													
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>				7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prima George</i> MD.													
10. CITY OR TOWN OF DEATH <i>Chesley (Det)</i>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Prima General Hospital</i>										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Owner - Gas Station</i>				12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE <i>Md.</i>										13b. COUNTY <i>Pr. Geo.</i>		13c. CITY OR TOWN <i>Seabrook</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>6301 - 93rd Avenue</i>									
14. FATHER'S NAME FIRST MIDDLE LAST <i>Charles Price, Jr.</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mildred I. Bishop</i>					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No -</i>										16b. SOCIAL SECURITY NO. <i>214-60-4497</i>		17. INFORMANT <i>Caren S. Price (Wife)</i>		ADDRESS <i>Same as Above</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Shotgun wound of the chest</i> 9551 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																									
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>5 P.M. 8-11 1980</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>Self-inflicted</i>													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Home</i>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>6304 93th Avenue, Tan Tan, Pr. Geo. Md</i>											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																									
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>										TITLE (SPECIFY) <i>Deputy</i>				MEDICAL EXAMINER				DATE SIGNED <i>8-11-80</i>							
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez M.D.</i>										ADDRESS <i>5009 Rayburn Ct., Camp Springs, Md.</i>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>										23b. DATE <i>8-14-1980</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cem.</i>				23d. LOCATION CITY OR TOWN COUNTY STATE <i>Brentwood Pr. Geo. Md.</i>									
24. FUNERAL DIRECTOR NAME <i>Nalley's F.H. Inc.</i> ADDRESS <i>Mt. Rainier, Md.</i>										25a. BALTIMORE CITY REGISTRAR <i>Aug 15 1980</i>				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>											

RECEIVED  
JUL 1 1964

TO: DIRECTOR, FBI  
FROM: SAC, NEW YORK (100-100000)

SUBJECT: JAMES EARL RAY, AKA  
RE: NEW YORK TELETYPE TO BUREAU, JULY 1, 1964

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		8021495		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
RALPH		J		PRINCE				AUGUST 13 1980		1237p M	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7 UNDER 1 YEAR MONTHS DAYS		7 UNDER 24 HRS HOURS MIN	
MALE		WHITE		JANUARY 16, 1916		64 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
VIRGINIA		USA				PRINCE GEORGES MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
ANDREWS AFB		MALCOLM GROW USAF MEDICAL CENTER						USAF		ADMINISTRATION	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS					
VIRGINIA		None		ALEXANDRIA		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4600 DUKE ST			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
NOT KNOWN - FOSTER PARENTS		NOT KNOWN - FOSTER PARENTS									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
YES		1951-1970		Selma Prince 4600 Duke St #1502 Alex. Va.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4151 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <u>POSSIBLE PULMONARY EMBOLUS</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>7 AUG</u> 19 <u>80</u> to <u>13 AUG</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>13 AUG</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Lucky Dunn</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>13 AUG 80</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
LUCKY DUNN, CAPT, USAF, MC		MALCOLM GROW USAF MED CEN ANDREWS AFB, MD 20331									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Removal		8/14/80		Georgetown University		Medical School Wash DC					
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Metropolitan Funeral Service		Alex, Va.				AUG 19 1980		<u>Henry McCreedy</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 385-1385.

FOR		STATE		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 0 2 1 4 9 6	
1- REGISTRAR		Film#G547 9-8-80 al		CERTIFICATE OF DEATH		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>AKA<sup>1ST</sup> M. Clifton Proctor<sup>MIDDLE</sup> MARTIN C<sup>LAST</sup> PROCTOR</b>				2a. DATE OF DEATH		2b. HOUR	
				MONTH DAY YEAR		4:40A.M.	
3 SEX <b>Male</b>		4 RACE <b>Black</b>		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
				MONTH DAY YEAR		71	
				OCT. 28, 1908			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
						<b>Prince Georges</b> MD.	
10. CITY OR TOWN OF DEATH <b>Clinton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Southern Maryland Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>WSSC Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Pr. Geo.</b>		13c. STREET ADDRESS	
				13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		<b>6214 Dower House Rd. 20870</b>	
14. FATHER'S NAME <b>Martin H. Proctor</b>				15. MOTHER'S MAIDEN NAME <b>Josephine Gray</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>217-36-8732</b>		17. INFORMANT ADDRESS <b>Mrs. Nettie F. Proctor, same as #13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>431- IMMEDIATE CAUSE (a) <u>Cerebral death and Cardiorespiratory arrest</u></b> DUE TO, OR AS A CONSEQUENCE OF <b>(b) <u>Ante mortem subdural hemorrhage</u></b> DUE TO, OR AS A CONSEQUENCE OF <b>(c) <u>Fall.</u></b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>States post operative problems for Aortic Stenosis. States post splenectomy for hemolytic anemia</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>unknown 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>Home</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>28 1980</b> to <b>29 1980</b> , that (I) (we) last saw the deceased alive on <b>29 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. <b>Natural</b>							
22b. SIGNATURE <b>Massoud Nemat</b> M.D.				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MASSOUD NEMAT, M.D.</b>				22e. ADDRESS <b>4235 28th Ave, Marlboro Heights, Md. 20031</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jul. 12, 80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Clinton, Maryland</b>	
24. FUNERAL DIRECTOR <b>Lee Funeral Home, Clinton, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 16 1980</b>		25b. REGISTRAR'S SIGNATURE	





# STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE REGISTRAR

1. DECEASED NAME  
(TYPE OR PRINT)

Robert

MIDDLE

LAST

PROCTOR

2a. DATE KNOWN  
OF DEATH  
ESTIMATED

MONTH

DAY

YEAR

8-31

1980

2b. HOUR

M

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH

MONTH

DAY

YEAR

8-8-23

57

YRS.

6. AGE (IN YEARS)

LAST BIRTHDAY

IF UNDER 1 YR.

MONTHS

DAYS

HOURS

MIN.

2c. DATE

PRONOUNCED

DEAD

8-31

1980

15

M

7a. BIRTHPLACE (STATE OR  
FOREIGN COUNTRY)

D.C.

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

9. BALTIMORE CITY OR COUNTY OF DEATH

Prince Georges

MD.

10. CITY OR TOWN OF DEATH

Hyattsville

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

Leahurst Memorial Hospital

12a. USUAL OCCUPATION (TYPE OF WORK  
FOR MOST OF WORKING LIFE)

Disable Veteran

12b. KIND OF BUSINESS  
OR INDUSTRY

None

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md.

13b. COUNTY

P.G.

13c. CITY OR TOWN

Hyattsville

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

4909 42nd. Pl.

14. FATHER'S NAME

Robert

MIDDLE

Lawrence

LAST

Proctor

15. MOTHER'S MAIDEN NAME

Elizabeth

MIDDLE

E.

LAST

Harley

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

Yes

16b. SOCIAL SECURITY NO.

WW11-Korean 578-18-1417

17. INFORMANT

Janet Proctor

ADDRESS

Same as 13e.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a) stating the under-  
lying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING

OR

CONTRIBUTING CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED

WHILE

NOT WHILE

AT WORK

AT WORK

21e. PLACE OF INJURY (AT HOME,

STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held an

Autopsy

Inspection

Inquiry

and in my opinion

death resulted from:

Natural causes

Accident

Suicide

Homicide

Undetermined manner

ACTUAL  
SIGNATURE

Augusto P. Rodriguez M.D.

TITLE (SPECIFY)

DEPUTY

MEDICAL EXAMINER

DATE  
SIGNED

9-1-80

EXAMINER'S NAME  
(TYPE OR PRINT)

AUGUSTO P. RODRIGUEZ M.D.

ADDRESS 5009 RAYBURN CT., CAMP SPRINGS, MD. 20031

23a. BURIAL, CREMATION, REMOVAL

Burial

23b. DATE

9/5/80

23c. NAME OF CEMETERY OR CREMATORY

Arlington N

23d. LOCATION

Arlington, Virginia

COUNTY STATE

24. FUNERAL DIRECTOR

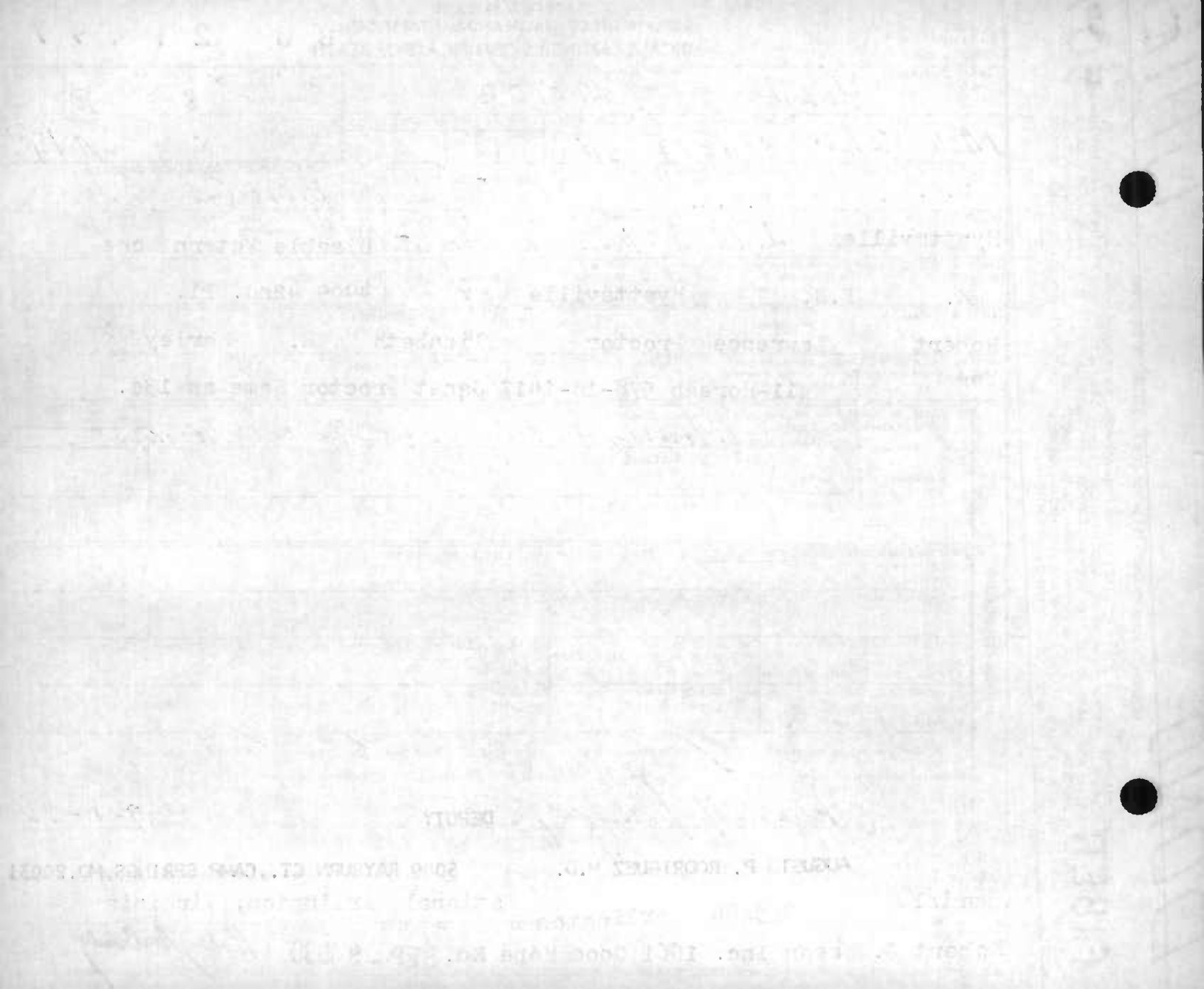
Robert G. Mason Inc. ADDRESS 1661 Good Hope Rd.

25a. DATE REC'D. BY REGISTRAR

SEP - 9 1980

25b. REGISTRAR'S SIGNATURE

R. G. Mason



## Medical Examiner Notified &amp; Released

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 1 4 9 8

FOR 1 - STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Halbert W. Pruitt</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>August 30, 1980</b>	
3 SEX <b>Male</b>		4 RACE <b>White</b>	
5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 20, 1916</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>P.G.</b> MD.	
10 CITY OR TOWN OF DEATH <b>Riverdale</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Leland Memorial Hospital</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Bus Operator</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>D.C.</b>	
13a. STATE <b>Md.</b>		13b. CITY OR TOWN <b>W. Hyatts.</b>	
13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>3709 Jefferson St.</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>John R. Pruitt</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Essie A. Smith</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>W.W. 11 579-24-5000</b>	
17. INFORMANT ADDRESS <b>Address Same as No # 13e.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute myocardial Infarct</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary Atherosclerosis</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Prev myocardial Infarct, Diabetes, Hypertension</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>minutes</b> <b>Yrs</b>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <b>7-19</b> 19 <b>77</b> to <b>8-30</b> 19 <b>80</b> , that (we) lost saw the deceased alive on <b>8-26</b> 19 <b>80</b> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) (I) did (did not) view the body after death.		22b. SIGNATURE <b>John L. Ford</b> M.D. DEGREE ATTENDING PHYSICIAN MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. DATE SIGNED <b>Aug. 31, 1980</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John L. Ford, M.D.</b>	
22e. ADDRESS <b>344 Univ. Blvd. W. Silver Springs, Md.</b>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	
23b. DATE <b>9-2-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wash. Natl. Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland P.G. Md.</b>		24 FUNERAL DIRECTOR NAME <b>F. Gasch's Sons F.H. P.A. Hyattsville, Md.</b>	
25a. DATE REC'D. BY REGISTRAR <b>SEP 3 1980</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 1 4 9 9 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) DONALD C. PURDY				2a. DATE OF DEATH MONTH DAY YEAR August 24, 1980				2b. HOUR 4:40p. M			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 19 1926		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges' County MD.					
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hosp. of Prince Geo. Cnty				12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Policeman		12b. KIND OF BUSINESS OR INDUSTRY Nat'l Capital			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. COUNTY P.G.		13c. CITY OR TOWN Seabrook		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9503 Goodluck Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST Elbridge --- Purdy				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha --- Headley							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 578-26-8077		17. INFORMANT ADDRESS Elbridge Purdy 4102 Norcross Str. Hillcrest Heights					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE PULMONARY EMBOLISM 410 - DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ACUTE MYOCELLULAR MYOCARDIAL INFARCTION A Day DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY DISEASE 2 yrs										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Hour	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) DIABETES MELLITUS & HYPERTENSION											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8-18 19 80, to 8-24 19 86, that (I) (we) lost the deceased alive on 8-24 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE A.C. LARA MD				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-24-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.C. LARA MD				22e. ADDRESS 9320 LANHAM-CROWN RD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 27 Aug. 1980		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland			
24. FUNERAL DIRECTOR NAME Beall F.H.				ADDRESS 9013 annapolis Rd. Lanham, Md.				25a. DATE OF RECORD AUG 27 1980			





*[Faint, mostly illegible text on lined paper, possibly bleed-through from the reverse side. Some words like "UNITED STATES" and "DEPARTMENT OF" are faintly visible.]*

*[Handwritten signature or name at the bottom left.]*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS ANTICIPATED. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE REGISTRAR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR												DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 21500	
1. DECEASED NAME (TYPE OR PRINT)						FIRST MIDDLE LAST						2b. DATE KNOWN OF DEATH				2c. DATE OF DEATH				7b. HOUR					
Eleanore Amanda REAMES												8-27 1980				8-27 1980				M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD				2d. HOUR									
Female		White		3-25-16		64 YRS.		MONTHS DAYS		HOURS MIN		8-27 1980				3:13 M									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)						7b. CITIZEN OF WHAT COUNTRY?						8. MARRIED				9. BALTIMORE CITY OR COUNTY OF DEATH									
Md						USA						WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				Baltimore City									
10. CITY OR TOWN OF DEATH						11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY									
Chesapeake Bay						Anne Arundel General Hospital						Housewife				-									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13a. INSIDE CITY LIMITS?				13b. STREET ADDRESS									
13a. STATE 13b. COUNTY 13c. CITY OR TOWN												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				3322 Buchanan St.									
14. FATHER'S NAME												15. MOTHER'S MAIDEN NAME													
FIRST MIDDLE LAST												FIRST MIDDLE LAST													
Joseph Malone												Estelle Smith													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO.						17. INFORMANT ADDRESS													
No						212-14-9684						Raymond Reames (Same as above)													
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I DEATH WAS CAUSED BY:																									
1749 IMMEDIATE CAUSE (a) Carcinoma of the heart																									
DUE TO, OR AS A CONSEQUENCE OF																									
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																									
(b) DUE TO, OR AS A CONSEQUENCE OF																									
(c)																									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																									
Pathological fracture of the right and femoral																									
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?													
8/12/80						Right femoral fracture						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)													
						9:50 P.M. 8-11 1980						Slipped by bed while assisted													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21f. LOCATION													
						Hospital						Georgetown Hosp. 3800 Reisterstown Rd., Baltimore, Md.													
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																									
ACTUAL SIGNATURE						TITLE (SPECIFY)						DATE SIGNED													
Augusto P. Rodriguez						M.D. Deputy						8/28/80													
EXAMINER'S NAME (TYPE OR PRINT)						ADDRESS																			
Augusto P. Rodriguez M.D.						5009 Rayburn Ct., Camp Springs, Md.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)						23b. DATE						23c. NAME OF CEMETERY OR CREMATORY						23d. LOCATION							
Burial						8-29-80						Ft. Lincoln Cemetery						Brentwood Pr. Geo. Md							
24. FUNERAL DIRECTOR NAME												ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Nalley's F.H. Inc.												Mt. Rainier, Md				SEP 1 1980									



James M. Jones  
1914-1915  
James M. Jones (James M. Jones)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 80 21501	
1. FOR STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ERNEST C REEDER			2a. DATE OF DEATH MONTH DAY YEAR 08 29 80			2b. HOUR 4:30 A.M.		
3 SEX Male		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR 11-15-1899		6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7 UNDER 1 YEAR MONTHS DAYS		7 UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD					
10 CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farming		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE 13b. COUNTY 13c. CITY OR TOWN Md Pr. George Aquasco						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 20709 Aquasco, Rd Aquasco, Maryland			
14 FATHER'S NAME FIRST MIDDLE LAST Potter Reeder				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie Broom							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-14-7770		17 INFORMANT Jenet Holly, Ch Rd, Washington, D.C.				ADDRESS 3610 Rock Creek			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Unknown.</u> 2765 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe dehydration</u> (c) <u>Severe Mal-nutrition</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Bacteremia</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (I) (this hospital) attended the deceased from 8-20-80, 19____, to 8-29, 19 80, that (I) (we) lost saw the deceased alive on 8-29, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (A) (we) (did) (did not) view the body after death.											
22b. SIGNATURE J. A. ANSAOZI				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. A. ANSAOZI				22e. ADDRESS							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9-2-80		23c. NAME OF CEMETERY OR CREMATORY St. Phillips Ch Cem			23d. LOCATION CITY OR TOWN COUNTY STATE Aquasco P.G. Md			
24 FUNERAL DIRECTOR NAME Martell Adams				ADDRESS Aquasco, Maryland				25a. DATE REC'D. BY REGISTRAR SEP 10 1980		25b. REGISTRAR'S SIGNATURE Rafael McCreary	

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1555-07-0000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8021502	
1- FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>BLANCHE E. REEVES</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>08-24-80</b>			2b. HOUR <b>9:08 AM</b>			
3. SEX <b>Female</b>		4. RACE <b>Cau</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 28 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S MD.</b>					
10. CITY OR TOWN OF DEATH <b>CHEVERLY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PRINCE GEORGE'S GENERAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>P. George's</b>		13c. CITY OR TOWN <b>N Carolton</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>5716 83rd Place</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Jacob Bittle</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Unobtainable</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>212-16-0371A</b>		17. INFORMANT ADDRESS <b>Son - Arthur Reeves, Jr. 5716 83rd Place, New Carolton, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiop. failure</b> 5990 DUE TO, OR AS A CONSEQUENCE OF: (b) <b>Sepsis, GI bleeding, Diabetes</b> DUE TO, OR AS A CONSEQUENCE OF: (c) <b>Urinary tract infection</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION <b>-</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (this hospital) attended the deceased from <b>8-13-80</b> 19 <b>80</b> to <b>8-24-80</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>8/23/80</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death.										22b. SIGNATURE <b>A. K. NARANJO</b> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> 22c. DATE SIGNED <b>8/24/80</b>	
22a. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. K. NARANJO</b>				22e. ADDRESS <b>PRINCE GEO. GEN. HOSPITAL</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Aug. 27, 80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Alexandria Va.</b>					
24. FUNERAL DIRECTOR NAME <b>Demaine Funeral Home, Alex. Va.</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 27 1980</b>		25b. REGISTRAR'S SIGNATURE <i>notary</i>					





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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VIR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Emma F. RESHENBERG		2a. DATE KNOWN OF DEATH ESTIMATED 8-10 1980		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 8-5-17 63	6. AGE (IN YEARS) LAST BIRTHDAY 63 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH Chesapeake (PA)		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Primer Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife
13a. STATE Pennsylvania		13b. COUNTY Unknown		13c. CITY OR TOWN Scottdale
14. FATHER'S NAME FIRST MIDDLE LAST John - Hutchins		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence - Klotz		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No None
16b. SOCIAL SECURITY NO. 579-07-5420		17. INFORMANT Shirley Reshenberg		ADDRESS 6500 Lamont Dr. New Carrollton, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE August D. Robinson		MEDICAL EXAMINER T. J. (SPECIFY) August D. Robinson		DATE SIGNED 8-10-80
EXAMINER'S NAME (TYPE OR PRINT) August D. Robinson		ADDRESS 5029 Bayview Ct., Camp Springs, Md.		
23a. BURIAL, CREMATION, OR REMOVAL (SPECIFY) Burial		23b. DATE Aug/13/80		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery
24. FUNERAL DIRECTOR NAME Chambers Funeral Home		ADDRESS Riverdale, Maryland		25a. DATE REC'D. BY REGISTRAR AUG 15 1980
				25b. REGISTRAR'S SIGNATURE

10-01-3

10-01-3

10-01-3

Medical Examiner notified

TO HOSPITAL-ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8021504

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HARRY WILLIAM RETTKE JR			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 16 1980		2b. HOUR 8:10AM
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR MAY 30 1934	6. AGE (IN YEARS LAST BIRTHDAY) 46 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.		
10. CITY OR TOWN OF DEATH ACCOKEEK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MG USAF MEDCEN AAFB DC		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) US ARMY RETIRED		12b. KIND OF BUSINESS OR INDUSTRY MILITARY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY PRNC GRGES		13c. CITY OR TOWN ACCOKEEK
14. FATHER'S NAME FIRST MIDDLE LAST HARRY WILLIAM RETTKE SR			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LILLIAN PHISTERER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) 1954-1978	17. INFORMANT ADDRESS DONNA S RETTKE/WIFE 1202 TERESA DR		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
---	--	---

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I (this hospital) attended the deceased from <u>16 AUG 80</u> to <u>17 AUG 80</u> , that I (we) last saw the deceased alive on <u>16 AUG 80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE M.D. - ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 17 AUG 80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) TERRY SALAN		22e. ADDRESS BALCON GROVE CRT M.C. ARNDT RD MD 20335			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8-21-80	23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia
24. FUNERAL DIRECTOR NAME Huntt Funeral Home, Waldorf, Maryland		25. DATE REC'D. BY REGISTRAR AUG 21 1980	

0801 L.S.P.H.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 30 21505	
1. DECEASED NAME (TYPE OR PRINT) <b>BERTHA L. RIDGEWAY</b>						2a. DATE KNOWN OF DEATH ESTIMATED <b>8-10-80</b>						2b. HOUR <b>4:35</b>									
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>7</b> DAY <b>18</b> YEAR <b>00</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>80</b> YRS.		IF UNDER 24 HRS. MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.		7c. DATE PRONOUNCED DEAD MONTH <b>8</b> DAY <b>10</b> YEAR <b>1980</b>		7d. HOUR <b>4:35</b>									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b> MD.									
10. CITY OR TOWN OF DEATH <b>LAUREL</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GLBH</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>home</b>									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																					
13a. STATE <b>Md</b>			13b. COUNTY <b>PG</b>			13c. CITY OR TOWN <b>Laurel</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>7501 Sandy Spring Road</b>									
14. FATHER'S NAME FIRST <b>Edgar</b> MIDDLE <b>Wines</b> LAST						15. MOTHER'S MAIDEN NAME FIRST <b>Betty</b> LAST <b>Pomeroy</b>															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>218 09 9026</b>				17. INFORMANT ADDRESS <b>Doris Blankenship same as above</b>													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cerebrovascular disease</b> <b>4370</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b>				TITLE (SPECIFY) <b>Deputy</b>				DATE SIGNED <b>8-10-80</b>													
EXAMINER'S NAME (TYPE OR PRINT) <b>Augusto P. Rodriguez M.D.</b>				ADDRESS <b>5009 Rayburn Ct., Camp Springs, Md.</b>																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Aug. 13, 1980</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Savage Cemetery</b>				23d. LOCATION <b>Savage, Maryland</b> COUNTY STATE									
24. FUNERAL DIRECTOR NAME <b>John H. Smith</b> ADDRESS <b>1000 1st St. N.E.</b>				25. DATE REC'D. BY REGISTRAR <b>AUG 20 1980</b>				25b. REGISTRAR'S SIGNATURE <b>Patricia McCreedy</b>													



Virginia

home

housewife

Vol. 1000, 1000, 1000

laurel

10 10

pottery

winner

heart

1000 1000 1000 1000 1000

1000 1000 1000

no

1000 1000 1000 1000 1000

1000 1000 1000

1000 1000 1000 1000 1000

1000 1000 1000

1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a DATE OF DEATH		MONTH		YEAR		2b HOUR	
Catherine Lena				ROBERTSON				August 31, 1980						4:10 PM	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR		IF UNDER 24 HRS.					
Female		White		October 28, 1924		55 YRS.		MONTHS		DAYS		HOURS		MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH									
Washington, D.C.		U.S.A.				Prince George's County MD									
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY									
Lanham		Doctors Hospital of P.G. County		Housewife		Home									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS					
Maryland		P.G. Co.		Mitchellville						18405 Queen Ann Ridge Road					
14 FATHER'S NAME FIRST		MIDDLE		LAST		15 MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST					
Onofrio		-		Carollo		Josephine		-		Ladato					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT		ADDRESS									
No		None		577-32-6030		Richard Gatton (Son-in-Law) Same as #13.									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY		IMMEDIATE CAUSE (a)		DUPLICATE MYOCARDIAL INFARCTION		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
410 -		(b)		Arteriosclerotic heart disease											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(c)		stroke Diabetes mellitus											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:															
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE											
22a certify that (I) (this hospital) attended the deceased from saw the deceased alive on above, (If yes) (did/did not) view the body after death.		22b SIGNATURE <i>[Signature]</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED									
22e PHYSICIAN'S NAME (TYPE OR PRINT) Tsuwiz CHA...		22f ADDRESS 6201 Greenbelt Rd Calver Park													
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE									
Burial		Sept/4/80		Walker Chapel Cemetery Arlington, Virginia		Calver Park									
24 FUNERAL DIRECTOR NAME		ADDRESS		25a DATE RECEIVED BY REGISTRAR		25b REGISTRAR'S SIGNATURE									
Chambers Funeral Home		Riverdale, Maryland		SEP 4 1980		<i>[Signature]</i>									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8021507			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
DILLARD C. ROGERS								08-27-80					7:30AM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White		August 1, 1905		75 YRS.		MONTHS		DAYS		HOURS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
South Carolina		U.S.A.				PRINCE GEORGE'S COUNTY MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
CHEVERLY		PRINCE GEORGE'S GENERAL HOSPITAL		Clerk		House of Rep.							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland		Montgomery		Silver Spring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1519 North Falkland Lane					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
Jesse S. Rogers		Mary Etta Owens											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS									
No		None		Mrs. Joseph E. Rogers Same As Item #13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION AND													
DUE TO, OR AS A CONSEQUENCE OF (b) AND PULMONARY EMBOLIS													
DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSIVE CARDIOVASCULAR DISEASE & DIABETES													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
		HOUR A.M. MONTH DAY YEAR											
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION									
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>				STREET		CITY OR TOWN COUNTY STATE							
22a. I certify that (1) this hospital attended the deceased from 8-4, 19 80, to 8-27, 19 80, that (1) (we) last saw the deceased alive on 8-27, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.													
22b. SIGNATURE		DEGREE		22c. DATE SIGNED									
J. GERTH		MD		8/27/80									
22d. ADDRESS		22e. DATE REC'D. BY REGISTRAR											
Prince Georges Hospital, Cheverly, Md.		SEP 2 1980											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. COUNTY STATE					
Burial		8/30/80		Norbeck Memorial Park		Olney		Mont. Md.					
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Hines/Rinaldi Funeral Home		11800 N.H.Ave. Silver Spring, Md.		SEP 2 1980									

PAGE : 7

08-55-BX

2007-08-20 14:00

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4. 932

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 21508

FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>Rosaléen Ann Sacks</b>			2a DATE OF DEATH MONTH DAY YEAR <b>August 8 80</b>		2b HOUR <b>2:10 PM</b>
3 SEX <b>Female</b>	4 RACE <b>White</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>Feb. 21 1930</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>50</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS HOURS MIN
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George</b> MD.	
10 CITY OR TOWN OF DEATH <b>Laurel</b>	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>16115 Jerald Rd.</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Md.</b>		13b COUNTY <b>P.G.</b>	13c CITY OR TOWN <b>Laurel</b>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS <b>16115 Jerald Rd.</b>
14 FATHER'S NAME FIRST MIDDLE LAST <b>Oren J. Mowrer</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Fitzgerald</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. <b>578-34-3989</b>		17 INFORMANT ADDRESS <b>John I. Sacks Same as 13e</b>	
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory suffocation</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic Breast cancer</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>+ CHF</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Extensive/prolonged chemotherapy / Radiation</b>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <b>Aug 8</b> 19 <b>80</b> to <b>Aug 8</b> 19 <b>80</b> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>Aug 8</b> 19 <b>80</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <b>Mark Andrews MD</b>		DEGREE <b>MD</b>		22c DATE SIGNED <b>8/8/80</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Mark Andrews MD</b>		22e ADDRESS <b>4140 Sandy Springs Rd</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>Aug. 11, 80</b>		23c NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. PK. Balto.</b>	
23d LOCATION CITY OR TOWN COUNTY STATE <b>Laurel Md.</b>		23e LOCATION CITY OR TOWN COUNTY STATE <b>Howard Md.</b>			
24 FUNERAL DIRECTOR NAME <b>Fleck Laurel Funeral Home Laurel, Md.</b>		24b DATE REC'D. BY REGISTRAR <b>Aug 12 1980</b>			

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
15M 7/77

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 80 21509	
1- DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Aubry E. Sansbury, Jr.</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>8 21 1980</b>			2b. HOUR M <b>3:27 p.m.</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 6, 1922</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) <b>58 YRS.</b>		7. IF UNDER 1 YR. MONTHS DAYS <b>0 0</b>		7. IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County</b>					
10. CITY OR TOWN OF DEATH <b>Cheverly</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Prince George's General Hosp. (DOA)</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sheet Metal-Worker</b>		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE <b>Md.</b>		13b. COUNTY <b>PG</b>		13c. CITY OR TOWN <b>Hyattsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>8136 15th Ave.</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Aubry E. Sansbury, Sr.</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mabel A. Gray</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>None</b>				16b. SOCIAL SECURITY NO. <b>577 28 1855</b>		17. INFORMANT ADDRESS <b>11575 Shadbrush Ct. Reston, Va. Diana Ritenour (Daughter)</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <b>Virginia L. Dolan</b>				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>8-22-80</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>				ADDRESS <b>111 Penn Street</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>8/27/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland PG Md.</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>Hines/Rinaldi F.H. 11800 N.H. Ave. S.S. Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG 28 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					



05-21-2

0801 8 200A



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 60M 1/73

(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) RAYMOND HAYWOOD SCHULTZ			2a. DATE OF DEATH MONTH DAY YEAR AUG. 21 1980			2b. HOUR 6:05 PM			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR SEPT 5 1907		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MINS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH. DC.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.			
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6604 CLINTON MANOR DR				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK		12b. KIND OF BUSINESS OR INDUSTRY CAFETERIA	
13a. STATE MD.				13b. COUNTY PR. GEO.		13c. CITY OR TOWN CLINTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES GEORGE SCHULTZ				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GERTRUDE BROWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 214-03-4625		17. INFORMANT WIFE ROSE SCHULTZ ADDRESS 6604 CLINTON MANOR DR-CLINTON			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> 1541 DUE TO, OR AS A CONSEQUENCE OF: (b) <u>CARCINOMA OF THE RECTUM WITH 13 MOS.</u> (c) <u>MULTIPLE METASTASES</u> DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 YRS.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>NONE</u>									
19a. DATE OF OPERATION JULY 18-1979			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA OF RECTUM			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTINUING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NONE			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR NONE		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) NONE				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> NONE			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) NONE		21f. LOCATION STREET CITY OR TOWN COUNTY STATE NONE				
22a. I certify that (I) (this hospital) attended the deceased from <u>OCT. 1955</u> to <u>PRESENT</u> , that (I) (we) lost saw the deceased alive on <u>AUG 18 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Arthur Shaver Jr. MD.						22c. DATE SIGNED AUG 21-1980		22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARTHUR SHAVER JR. MD.	
22e. ADDRESS 9131 PISCATAWAY RD. CLINTON MD. 20735						22f. MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/25/80		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Md.		
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc. 6633 Old Alexander Ferry Road Clinton, Md.									

6633 Old Alexander Ferry Road Clinton, Md.

SEP 2 1980

Maryland

THE UNIVERSITY OF CHICAGO  
LIBRARY

COMMON LIBRARY

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THE UNIVERSITY OF CHICAGO  
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CHICAGO, ILL. 60607

BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/76

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 7 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST ERIC		MIDDLE D.		LAST SEALS		2a. DATE KNOWN OF DEATH ESTIMATED		MONTH 8		DAY 29		YEAR 1980		2b. HOUR M	
3 SEX male		4. RACE negro		5. DATE OF BIRTH MONTH AUG DAY 3, YEAR 1980		6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 1		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH 8		DAY 29		YEAR 1980	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.											
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's Gen. Hosp. (DOA)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE		12b. KIND OF BUSINESS OR INDUSTRY NONE											
13a. STATE N/A		13b. COUNTY N/A		13c. CITY OR TOWN WASH. DC.		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS 1400 S STREET S.E.									
14. FATHER'S NAME FIRST UNK		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME MARIE SEALS		MIDDLE		LAST							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. NONE		17. INFORMANT WILLIE P. SEALS		ADDRESS 1400 S STREET S.E.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome 7980 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE 		M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED 8-30-80											
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.		ADDRESS 111 Penn St.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE SEPT 9, 1980		23c. NAME OF CEMETERY OR CREMATORY WASHINGTON NATIONAL		23d. LOCATION CITY OR TOWN SUITE LAND, MD COUNTY STATE											
24. FUNERAL DIRECTOR ALEXANDER S. POPE		24b. ADDRESS 2617 PENNSYLVANIA AVE		25a. DATE REC'D. BY REGISTRAR SEP 15 1980		25b. REGISTRAR'S SIGNATURE 											



SECRET



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 1 5 1 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Earl Shaffer</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>08-18-80</b>			2b. HOUR <b>2:30 P.M.</b>	
3. SEX <b>Male</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>05 25 03</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George</b> MD.	
10. CITY OR TOWN OF DEATH <b>Suitland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suitland Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Electrician</b>	
12b. KIND OF BUSINESS OR INDUSTRY		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md</b> 13a. COUNTY <b>Pr Geo</b> 13c. CITY OR TOWN <b>Lanham</b>		13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS <b>7919 Johnson Ave</b>	
14. FATHER'S NAME FIRST <b>James</b> MIDDLE <b>Shaffer</b> LAST <b>Shaffer</b>		15. MOTHER'S MAIDEN NAME FIRST <b>unknown</b> MIDDLE <b>LOUISE</b> LAST <b>WOODLAND</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>unknown</b> (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>194-10-5366</b>	
17. INFORMANT ADDRESS <b>Suitland</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **ISCHEMIC STROKE** **436-**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **CEREBRAL ARTERIOSCLEROSIS** DUE TO, OR AS A CONSEQUENCE OF

(c) **History of anemia.** DUE TO, OR AS A CONSEQUENCE OF

YEARS. **Months.** YEARS. **years.**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

**HISTORY OF RIGHT SIDED HEMIPARESIS. CHRONIC BRAIN SYNDROME**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb. 1</b> 19 <b>78</b> , to <b>Aug. 18</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>Aug. 18</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Peter W. Yim M.D.</b> DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>AUG. 18 1980</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PETER W. YIM M.D.</b>				22e. ADDRESS <b>7900 OLD BRANCH AVE. CLINTON, MARYLAND 20735</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <b>8-21-1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Miskyt Hill Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bethlehem PA</b>	
24. FUNERAL DIRECTOR NAME <b>H.S. Washington</b> ADDRESS <b>4925 Nantux H Bunkowsky</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 27 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Jeffrey McCreedy</b>			

DATE: 11/07/2017

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 38 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Medical Examiner notified and Approved

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80 21513	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELLA M SHORES						2a. DATE OF DEATH MONTH DAY YEAR 8/9/80			2b. HOUR 6 <sup>00</sup> AM		
3. SEX FEMALE		4. RACE CAU		5. DATE OF BIRTH MONTH DAY YEAR SEPT 15, 1892		6. AGE (IN YEARS LAST BIRTHDAY) 87 yrs		7. UNDER 1 YEAR MONTHS DAYS HOURS MINS		7. UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PR. GEO MD.					
10. CITY OR TOWN OF DEATH OXON HILL		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8837 OAK LANE OXON HILL Md				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md Pr Geo OXON HILL						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8837 OAK LANE OXON HILL			
14. FATHER'S NAME FIRST MIDDLE LAST RUEUS BOLDEN						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST COALIE A MABE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 414-84-5401		17. INFORMANT ADDRESS HASSIE MITCHELL 8837 OAK LANE OXON HILL					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIAC ARRHYTHMIA</u> 4029 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>HYPERTENSIVE HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CHRONIC RENAL INSUFFICIENCY</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CHRONIC RENAL INSUFFICIENCY</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>FEB</u> , 19 <u>80</u> , to <u>AUG 9</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>AUG 6</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>J. Sanford Young, MD</u> DEGREE <u>MD</u>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>8/9/80</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>J. SANFORD YOUNG, MD</u>						22e. ADDRESS <u>9401 INDIAN HEAD HWY, OXON HILL, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE AUG 12 1980		23c. NAME OF CEMETERY OR CREMATORY WESLEY CHAPEL		23d. LOCATION CITY OR TOWN COUNTY STATE MOUNTAIN CITY JOHNSON TENN					
24. FUNERAL DIRECTOR'S NAME <u>CECIL KALAS</u> ADDRESS <u>6160 OXON HILL RD OXON HILL Md</u>						25. DATE REC'D. BY REGISTRAR <u>AUG 13 1980</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 0 2 1 5 1 4	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
MARGARET V. SINES		08-24-80		3:40AM	
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	White	Sept. 10, 1916	63	MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH		
Virginia	U.S.A.		PRINCE GEORGES MD.		
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
CHEVERLY	PRINCE GEORGES GENERAL HOSPITAL		Housewife		Own Home
13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? 13e. STREET ADDRESS					
Md. P.G. Greenbelt YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 7909 Mandan Rd. Apt - 104					
14 FATHER'S NAME (First Name Unknown) Holtzclaw			15 MOTHER'S MAIDEN NAME (Last Name Unknown) Clara		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS Address Same as No# 13e.	
No		215-20-4088		Ralph R. Sines	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Advanced Metastatic Carcinoma of the Pancreas</u> 23 mo					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1579 DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
DUE TO, OR AS A CONSEQUENCE OF					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8-16-80, to 8-24-80, that (I) (we) last saw the deceased alive on 8-22-80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death		22b. SIGNATURE M. Baig M.D.		22c. DATE SIGNED 8/24/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. BAIG, MD		22e. ADDRESS 3400 FORTMEADE RD, LAUREL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-26-80		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
Brentwood P.G. Md.		AUG 27 1980		L. H. McCreedy	
24 FUNERAL DIRECTOR F. Gasch's Sons F.H. P.A. Hyattsville, Md.					





8/27/80

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 80 21515			
1. DECEASED NAME (TYPE OR PRINT) <b>BURT D. SLADEN</b>				2a. DATE OF DEATH MONTH <b>8</b> DAY <b>19</b> YEAR <b>80</b>				2b. HOUR <b>6:30</b> M			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>June</b> DAY <b>28</b> YEAR <b>1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS.		7. UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		7. UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash. D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b> MD.					
10. CITY OR TOWN OF DEATH <b>Clinton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Southern Maryland Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>P?E.P.C.O.</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13b. STREET ADDRESS <b>6209 Allen Court</b>			
13a. STATE <b>Md.</b>		13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Temple Hills</b>		14. FATHER'S NAME FIRST <b>William A.</b> MIDDLE <b>Sladen</b> LAST <b></b>				15. MOTHER'S MAIDEN NAME FIRST <b>Grace</b> MIDDLE <b>Tydings</b> LAST <b></b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WW11</b>		17. INFORMANT ADDRESS <b>Lisette B. Sladen (Wife) same as #13</b>							
II CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> <b>1890</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>METASTATIC CARCINOMA OF L KIDNEY</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b> <b>7 MOS</b>	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR <b>A.M.</b> MONTH <b></b> DAY <b>19</b> P.M. <b></b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <b></b> CITY OR TOWN <b></b> COUNTY <b></b> STATE <b></b>							
22a. I certify that (I) (the hospital) attended the deceased from <b>AUGUST 1</b> 19 <b>80</b> , to <b>AUGUST 17</b> 19 <b>80</b> , that (I) (two) last saw the deceased alive on <b>AUGUST 19</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.											
22b. SIGNATURE <b>James G. Brown MD</b>				DEGREE <b></b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>8/19/80</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES A. BROWN MD</b>				22e. ADDRESS <b>6525 BELCAST RD HATTSVILLE MD 20782</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/22/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cheltenham Md. Vet.</b>		23d. LOCATION CITY OR TOWN <b>Cheltenham</b> COUNTY <b>P.G.</b> STATE <b>Md.</b>					
24. FUNERAL HOME OR OTHER INSTITUTION <b>Lee Funeral Home Inc.</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG 25 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			
26. ADDRESS <b>63 Old Alexander Ferry Road Clinton Md.</b>											



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## MEDICAL EXAMINER NOTIFIED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbonpapers Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										700 21516	
1- FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>FRANK SMITH</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>08 02 80</b>		2b. HOUR <b>3:37 P M</b>			
3 SEX <b>MALE</b>		4 RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>AUG. 30, 1910</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S COUNTY MD.</b>					
10. CITY OR TOWN OF DEATH <b>UPPER MARLBORO</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4651 PEERLESS AVENUE.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CUSTODIAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>PRIVATE</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>PRINCE GEORGE</b> 13c. CITY OR TOWN <b>UPPER MARLB.</b>						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4651 PEERLESS AVENUE,</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>JAMES E. SMITH</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY DORSEY</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>218-03-5054</b>		17. INFORMANT ADDRESS <b>UPPER MARLBORO, MARYLAND</b> <b>CARRIE SMITH/WIFE 4651 PEERLESS AVENUE.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarct</b> <b>410 -</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio sclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) <del>the hospital</del> attended the deceased from <b>7/25</b> , 19 <b>80</b> , to <b>8/2</b> , 19 <b>80</b> , that (I) <del>was</del> lost <b>7/25</b> saw the deceased alive on <b>7/25</b> , 19 <b>80</b> , and that in (my) <del>four</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>did</del> <b>did not</b> view the body after death.											
22b. SIGNATURE OF PHYSICIAN <b>A. C. HOLMES, M.D.</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8/2/80</b>		MD.	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. C. HOLMES, M.D.</b>						22e. ADDRESS <b>14314 OLD MARLBORO PIKE, UPPER MARLB.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>AUG. 7, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MOSES CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>LOTHIAN, MARYLAND</b>			
24. FUNERAL DIRECTOR <b>ROLLINS FUNERAL HOME, INC. 4339 HUNT PL. N.</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG 8 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ESTI- MATED		xx	MONTH	DAY	YEAR	2b. HOUR
Andrew Lee Spearman					8 16 19 80						12:55
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR
male	white	Oct 27 1955		24	MONTHS DAYS HOURS MIN.				8 16 19 80		12:55
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Washington D.C.		USA					Prince George County MD				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly		Prince George General Hospital				Construction					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Md.		Pr. Geo.		Tak. Park				617 Elm Avenue			
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME						
Lawrence W. Spearman					Emma J.						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No		215 66 9501		Lawrence W. Spearman,		617 Elm Ave					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>Multiple Injuries</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Multiple Injuries</b>		
(b) <b>Multiple Injuries</b>		
(c) <b>Multiple Injuries</b>		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>5:55xx 8/16 19 80</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>ejected driver of auto/lost control/fixed object/</b>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>roadway</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>University Blvd/Rt#1, College Park, PG Co. MD</b>	
22a. I certify that I took charge of the remains described above, held on death resulted from: <b>Accident</b> <input checked="" type="checkbox"/> <b>Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> and in my opinion <b>Assistent</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined manner</b> <input type="checkbox"/>					
ACTUAL SIGNATURE <b>H.R. Guard</b>		TITLE (SPECIFY) <b>Assistent</b>		DATE SIGNED <b>8/17/80</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>		ADDRESS <b>111 Penn Street, Balto., MD 21201</b>			

23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <b>Burial</b>		23b. DATE <b>Aug 21, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Dylstead Bp'l Church Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Clinton North Carolina</b>	
24. FUNERAL DIRECTOR (NAME) <b>Takora Funeral Home</b>		ADDRESS <b>254 Canal St NW DC</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 20 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Dorothy McBrady</b>	



Oct 27 1982

Construction

617 Elm Avenue

York Park

Pr. Geo.

Mr.

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Form

Spencer

Lawrence W.

215 66 2501 Lawrence W. Spencer, 617 Elm Ave

Mr.

Spencer

TO HOSPITAL OR ATTENDING PHYSICIAN. The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										700 21518	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>HOMER L. STANFORTH</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>08-08-80</b>			2b. HOUR <b>11:20 PM</b>			
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Feb. 12, 1883</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>97</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S</b> MD.					
10 CITY OR TOWN OF DEATH <b>CHEVERLY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PRINCE GEORGE'S GENERAL HOSP.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Dept. of Justice</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-U.S. Govt.</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Md.</b>		13b. COUNTY <b>Pr. Geo.</b>		13c. CITY OR TOWN <b>Adelphi</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>9007 - Highland Dr.</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>Franklin A. Stanforth</b>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Margaret Leeka</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>-</b>		17. INFORMANT <b>Elsie S. Burgess (Dtr.)</b>		ADDRESS <b>Same as above</b>					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebro Vascular Thrombosis</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>A-S-H-D</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Coronary Artery Disease</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (his hospital) attended the deceased from <b>Aug 8</b> 19 <b>80</b> to <b>July 13</b> 19 <b>75</b> , that (I) (we) lost <b>60</b> above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>[Signature]</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8-9-80</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>8-11-1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cem.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood Pr. Geo. Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Nalley's F.H. Inc. Mt. Rainier, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG 13 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8021519			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Norine Fowler Stitt				2a. DATE OF DEATH MONTH DAY YEAR 8/6/80		2b. HOUR 1:06 pm	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Feb. 11, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 63	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.	
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired (Sec.)		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Anne Arundel		13c. CITY OR TOWN Harwood	
14. FATHER'S NAME FIRST MIDDLE LAST Floyd M. Foster				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie Marie ?			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO 577-28-2819		17. INFORMANT Nancy Kay Davis, Gaithersburg, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Decomment cerebral hemorrhage</u> 2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Severe hypertension atherosclerosis</u> (c) <u>Diabetes mellitus, acute renal failure</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Annette Consolves</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/7/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Annette Consolves				22e. ADDRESS Waldorf, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 8/7/80		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematorium		23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C.	
24. FUNERAL DIRECTOR NAME C.F. Bell				ADDRESS Lee Funeral Home, Inc., Clinton, Md.		25a. DATE REC'D. BY REGISTRAR AUG 12 1980	
				25b. REGISTRAR'S SIGNATURE <u>John H. Bell</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8021520 REG. NO.					
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FLORENCE E. STOKES				August 18, 1980				6:58 pm	
3 SEX Female		4 RACE Caucasion		5. DATE OF BIRTH MONTH DAY YEAR 2/10/96		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 84		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.			
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hosp. of Prince Geo. Cnty				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Md				13b. COUNTY Pro Georges		13c. CITY OR TOWN Greenbelt		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Christian Decking				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lizzie Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO 194 07 8081		17. INFORMANT ADDRESS Jean E Kemmerer Greenbelt, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiorespiratory Failure</u> 3319 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>SENILITY CEREBRAL CORTICAL ATROPHY</u> (c) <u>Pneumonia</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>5-20-1980</u> to <u>8-18-1980</u> , that (I) (we) lost the deceased alive on <u>8-18-1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE M. S. Nayyar				DEGREE				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SANKARAN M. NAYYAR, MD.				22e. ADDRESS 3712-38th AVE COTTAGE CITY, MD 20722					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug 22, 1980		23c. NAME OF CEMETERY OR CREMATORY George Washington		23d. LOCATION CITY OR TOWN COUNTY STATE Hyattsville Pro Georges Md.			
24. FUNERAL DIRECTOR NAME F. Gasch's Sons				ADDRESS P A Hyattsville, Md		25. DATE REC'D BY REGISTRAR AUG 22 1980		25. REGISTRAR'S SIGNATURE	



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21521	
1. DECEASED NAME (TYPE OR PRINT) <b>ROBERT L. SWANSON</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> <b>8 2 80</b>		2b. HOUR <b>8:40</b>		2c. DATE PRONOUNCED DEAD <b>8 2 19 80</b>	
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec 30, 1916</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>63</b> YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Cheverly</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Prince George's Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Gov't Employee</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Prince George</b>		13c. CITY OR TOWN <b>Hyattsville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5844 Jamestown Road</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>late William K Swanson</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>late Clara</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>578 05 0580</b>		17. INFORMANT ADDRESS <b>Louise Yauger 6013 Misty Arch Rd 21044</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive arteriosclerotic cardiovascular disease</b> <b>4029</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Margarete J. Korell</b>				TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER				DATE SIGNED <b>8-3-80</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>				ADDRESS <b>111 Penn Street</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Aug. 5, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Prince George Co Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Harry H Witzke 4112 Columbia Rd Ellicott City</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG 5 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Robert M. Crady</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1. FOR STATE REGISTRAR					8 0 2 1 5 2 2					
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					
Ann C. TAYLOR					MONTH DAY YEAR 8 11 80					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR		
Female		White		MONTH DAY YEAR Nov. 6, 1894		85 YRS.		2:40 P.M.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Ireland		USA				Prince-Georges MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Hyattsville		Sacred Heart Home				Nurse				
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland					Montgomery		Kensington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					
James MURRAY					Mary MURRAY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO					689-2418207		Mrs. Ann T. Eller #13 (daughter)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY										
IMMEDIATE CAUSE (a) <i>Hypostatic Pneumonia</i>										
4292 DUE TO, OR AS A CONSEQUENCE OF										
(b) <i>Chronic Heart Failure</i>										
DUE TO, OR AS A CONSEQUENCE OF										
(c) <i>Arteriosclerotic Cardiovascular Disease</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
			HOUR A.M. MONTH DAY YEAR P.M. 19							
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION				
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>4/29</i> , 19 <i>80</i> , to <i>5/11</i> , 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>5/11</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					DEGREE		22c. DATE SIGNED			
<i>Bernard A. Fitzgerald MD</i>					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		<i>5/11/80</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS					
Bernard A. Fitzgerald MD					217 University Blvd. E. S.S. Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial			8/13 80		Arlington Nat'l		CITY OR TOWN COUNTY STATE Arlington, Va.			
24. FUNERAL DIRECTOR'S NAME					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
W.W. Taltavull					AUG 15 1980		<i>Anthony M. Brady</i>			
4748 Wisv. Ave. N.W. Wash. D.C. 20016										

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2025 RELEASE UNDER E.O. 14176

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DATE: 2/2/89

Frankford, Pa.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1 - FOR STATE REGISTRAR					8 0 2 1 5 2 3 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helen M Taylor					2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR 8-10-80 12 42 PM					
3 SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 4 29 16		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D C		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.				
10. CITY OR TOWN OF DEATH Laurel, Md		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greentree Laurel Belts Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cafeteria work		12b. KIND OF BUSINESS OR INDUSTRY school		
13a. STATE Md					13b. COUNTY Pro Georges Beltsville		13c. CITY OR TOWN Beltsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Robert Andrews					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha A Cole					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 219 46 7853		17. INFORMANT ADDRESS Bertram Taylor Same as no 13a					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY Arrest</u> 496- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>SEVERE CHRONIC OBSTRUCTIVE Pulmonary DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>8-10-80</u> , 19 <u>80</u> , to <u>8-10-80</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>8-10-80</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death.										
22b. PHYSICIAN'S NAME (TYPE OR PRINT) M. H. Chaudhry, M. D.					DEGREE MD		22c. DATE SIGNED 8-10-80		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Aug 13, 1980		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pro Georges Md.			
24. FUNERAL DIRECTOR NAME F. Gasch's Sons P A Hyattsville, Md.					25a. DATE REC'D. BY REGISTRAR AUG - 5 1980		25b. REGISTRAR'S SIGNATURE [Signature]			

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 2 1 5 2 4	
1. FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
DONALD DEAN THOMAS						AUGUST 8 1980			9:00A M		
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS HOURS MIN	
MALE		WHITE		APRIL 25 1929		51 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
ILLINOIS		USA				PRINCE GEORGES COUNTY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
ANDREWS AFB		MALCOLM GROW USAF MED CENTER						NAVIGATOR		NAVY	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		
DELAWARE			SUSSEX		REHOBETH		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RD 1 BOX 530		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
FRANCIS ALLEN THOMAS			PEARL OLLIE SIMS								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS						
YES			KOREAN		334-22-7700 JEAN THOMAS RD 1 BOX 530, REHOBETH, DEL.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST										8900	
1991 DUE TO, OR AS A CONSEQUENCE OF adenocarcinoma metastatic primary unk											
(b) Adenocarcinoma, metastatic - primary unknown											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Presumed sepsis											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
N/A			N/A								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 23 JULY 1980, to 8 AUG 1980, that (I) (we) last saw the deceased alive on 8 AUG 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
Thomas T. Yasuhara MD									8 AUG 80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
THOMAS T. YASUHARA			MG USAF MED CEN, AAFB, MD 20331								
23a. BURIAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
CREMATION			8-9-1980		CEDAR HILL CREM.		SUITLAND PGC. Md.				
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
W. W. CHAMBERS Co.			RIVERDALE, Md.			AUG 13 1980					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

Medical Examiner Notified

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8021525			
FOR 1- STATE REGISTRAR					REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) ELIZABETH M. THOMPSON					2a DATE OF DEATH MONTH DAY YEAR 8 14 80			2b HOUR 11:06 M
3 SEX Female MALE		4 RACE NEGRO		5 DATE OF BIRTH MONTH DAY YEAR 2-23-1907		6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.		
10 CITY OR TOWN OF DEATH CLINTON		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MD.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland					13b COUNTY P.G.		13c CITY OR TOWN Clinton	
14 FATHER'S NAME FIRST MIDDLE LAST Martin Proctor					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Gray			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b SOCIAL SECURITY NO 220-32-7496		17 INFORMANT ADDRESS Pearline Wilson Rt. 1 Box 107 Waldorf, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured Abdominal Aneurysm</u> 44/3 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>Years</u> <u>Years</u>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a DATE OF OPERATION 8/14/80		19b CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured Abdominal Aneurysm			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (Mrs hospital) attended the deceased from <u>10/18</u> 19 <u>65</u> , to <u>8/14</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>8/14</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.								
22b SIGNATURE Thomas L. Fieldson MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 8/15/80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS L. FIELDSON					22e ADDRESS Brandywine, Md. 20613			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 8/18/1980		23c NAME OF CEMETERY OR CREMATORY Resurrection Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Clinton P.G. Md.		
24 FUNERAL DIRECTOR NAME Martell Adams		ADDRESS Aguasco, Md.		25a DATE REC'D. BY REGISTRAR AUG 19 1980		25b REGISTRAR'S SIGNATURE		

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*[Faint, illegible handwriting on lined paper]*



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										78021526			
1. FOR STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) HELEN R. TILLMAN					2a. DATE OF DEATH MONTH DAY YEAR 08-22-80					2b. HOUR 11:35PM			
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH August 8 <sup>th</sup> 1922		6. AGE (IN YEARS LAST BIRTHDAY) 58		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.							
10 CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGES GENERAL HOSPITAL				12a. USUAL OCCUPATION Cashier		12b. KIND OF BUSINESS OR INDUSTRY Retail					
13a. STATE Maryland					13b. COUNTY Pr. George		13c. CITY OR TOWN Clinton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2004 Floral Park Road		
14 FATHER'S NAME Bernard					15 MOTHER'S MAIDEN NAME Elayne Fitzgerald								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 577-20-7006		17. INFORMANT Elizabeth Dotson Address 15924 Livingston Road Accokeek, Maryland								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 4169 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) pulmonary edema (c) pulmonary												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK HOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) this hospital attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE E. Gerth, M. D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS Prince George's General Hospital Cheverly, Maryland									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 8/26/80		23c. NAME OF CEMETERY OR CREMATORY Washington Nat'l. Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Pr. Geo. Md.			
24. FUNERAL DIRECTOR Hill Rd.				25a. DATE REC'D. BY REGISTRAR AUG 27 1980				25b. REGISTRAR'S SIGNATURE Pistony McCreedy					

MEDICAL CERTIFICATION





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN FOUR HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

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(VR A15 ME (5))  
15M/7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 21527

1. FOR STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT)		FIRST Mamie		MIDDLE TREM		LAST BELAS		2b. DATE KNOWN OF DEATH ESTIMATED		MONTH 8		DAY 16		YEAR 1980		2d. HOUR M					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5-1-00		6. AGE (IN YEARS) LAST BIRTHDAY 80 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD		MONTH 8		DAY 16		YEAR 1980		2d. HOUR M					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Primer belongs MD											
10. CITY OR TOWN OF DEATH Clinton				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10513 Thrift Road, Clinton								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY Home							
13a. STATE Florida				13b. COUNTY Pinellas				13c. CITY OR TOWN Clearwater				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 1254 Bayshore Blvd.							
14. FATHER'S NAME FIRST MIDDLE LAST Sam Debnam				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Robinson																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 577-84-3892				17. INFORMANT Helen Morrow				ADDRESS Lauder Hill, Florida 2085 Northwest 46 Ave.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?														20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE <u>Augusto P. Rodriguez</u>				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER				DATE SIGNED 8-16-80											
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez M.D.				ADDRESS 5009 Rayburn Ct., Camp Springs, Md. 20032																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Aug 19, 1980				23c. NAME OF CEMETERY OR CREMATORY Sylvan Abbey Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Clearwater Pinellas Fla.											
24. FUNERAL DIRECTOR NAME 6633 Old Alexander Ferry Rd. Clinton, Md				ADDRESS				25a. DATE REC'D. BY REGISTRAR AUG 21 1980				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>											

6833 Old Lexington Ferry Rd. Clinton, N.Y.  
Lee Funeral Home, Inc.  
August 1968



Handwritten text, possibly a date or reference number, written vertically on the right margin.

## MEDICAL EXAMINER NOTIFIED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8021528 REG. NO.							
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>HARRY A. TRIPLETT</b>				08-27-80				6:15A <sub>M</sub>			
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JULY 25, 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>73</b> YRS.		7. IF UNDER 1 YEAR		7. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASHINGTON, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S COUNTY MD.</b>					
10. CITY OR TOWN OF DEATH <b>CHEVERLY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH PLACE, GIVE STREET ADDRESS) <b>PRINCE GEORGE'S GENERAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CONSTRUCTION</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CAFRTZ CO.</b>			
13a. STATE <b>MARYLAND</b>				13b. CITY OR TOWN <b>BOWIE</b>		13c. STREET ADDRESS <b>16109 ALDERWOOD LANE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>LINEA TRIPLETT</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNA ALEXANDER</b>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>YES 1926-1929</b>			
16b. SOCIAL SECURITY NO. <b>578 20 7322A</b>				17. INFORMANT ADDRESS <b>LAND, BOWIE, MARYLAND</b>				17. INFORMANT <b>MRS. ELMIRA K. TRIPLETT/WIFE/16109 ALDERWOOD</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Plasma Aortic Coronary heart dis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>metastatic carcinoma</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1991</b> hours months								PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Cerebrovascular disease</b>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>7/11/80</b> , to <b>8/27/80</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>David M. Goldman</b>				DEGREE <b>M.D.</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8/27/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DAVID GOLDMAN, M.D.</b>				22e. ADDRESS <b>6525 BELCREST RD, HYATTSVILLE MD 20782</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>AUG. 30, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HARMONY CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>LANDOVER PG MARYLAND</b>					
24. FUNERAL DIRECTOR NAME <b>ROLLINS FUNERAL HOME, INC.</b>						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>SEP 2 1980</b>					
4339 HUNT PLACE, N. E. WASH. D.C.											

RECEIVED JAN 14 1964

HARRY A. TRIPLETT

08-27-60

6:12A

PRINCE GEORGE'S COUNTY

PRINCE GEORGE'S GENERAL HOSPITAL

CHIEF

8252 BELMONT RD, HYATTSVILLE MD 20725

DAVID GOLDMAN, M.D.

2525 000

333-2100-2100, R. E. JAMES, JR.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

# STATE OF MARYLAND

## DEPARTMENT OF HEALTH AND MENTAL HYGIENE

### CERTIFICATE OF DEATH

21529

1. DECEASED-NAME (Type or print) <b>Hilda</b> First <b>--</b> Middle <b>--</b> Last <b>Tuck</b>			2a. DATE OF DEATH Month <b>August</b> Day <b>21</b> Year <b>1980</b>			2b. HOUR <b>00</b> MIN <b>00</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Oct. 4, 1895</b>		6. AGE (In years last birthday) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS <b>00</b> DAYS <b>00</b> HOURS <b>00</b> MIN <b>00</b>	
7a. BIRTHPLACE (State or foreign country) <b>Belgium</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's</b> Md.			
10. CITY OR TOWN OF DEATH <b>Upper Marlboro</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>13401 Oak Grove Drive</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Pr. Geo's</b>		13c. CITY OR TOWN <b>Upper Marlboro</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>13401 Oak Grove Rd</b>	
14. FATHER'S NAME First <b>Edward</b> Middle <b>--</b> Last <b>Bunge</b>			15. MOTHER'S MAIDEN NAME First <b>Unk.</b> Middle <b>Unk.</b> Last <b>Karcher</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT <b>"Perrywood", 13401 Edward H. Tuck-Oak Grove Rd., Upper Marlboro, Maryland 20870:</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer</b> <b>4370</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis cerebral</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>2 yrs</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 mo</b> <b>2 yrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION <b>9</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>May</b> , 19 <b>78</b> , to <b>21 Aug</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>20 Aug</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Robert B. Sasscer</b>				M.D. DEGREE <b>M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>8/21/80</b>	
22d. PHYSICIAN'S NAME (Type) <b>Robert B. Sasscer, M.D.</b>				22e. ADDRESS <b>Upper Marlboro, Maryland 20870</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE <b>8/22/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland (Pr. Geo's) Md.</b>			
24. FUNERAL DIRECTOR <b>Richard A. Coleman - Upper Marlboro Funeral Home</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 28 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur H. H. H.</b>			





1980:01, 21, 1980:01

White

1980:01, 21, 1980:01

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BP  
DHMH - 17  
(VR A15 ME (3))  
15M 7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE ADVISE THE DIVISION OF VITAL RECORDS. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE MEDICAL EXAMINER. GIVE PAGE 5 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE KNOWN OF DEATH	
GEORGIA TYLER										MONTH DAY YEAR HOUR <input checked="" type="checkbox"/> 7 18 1980	
2. SEX 4. RACE										5. DATE OF BIRTH	
female negro										MONTH DAY YEAR March 10, 05	
6. AGE (IN YEARS)										7. CITIZEN OF WHAT COUNTRY?	
75 YRS.										U.S.A.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH										12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly										Homemaker	
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12c. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Prince George's General Hospital										Prince George's County MD	
13a. STATE 13b. COUNTY										13c. CITY OR TOWN	
D.C.										Washington	
14. FATHER'S NAME (FIRST MIDDLE LAST)										15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)	
Willie Gunter										Lizie Gunter	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)										16b. SOCIAL SECURITY NO.	
No										579-10-2570	
17. INFORMANT ADDRESS										18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
Albert Diggs 746 51st S.E. Washington, D.C.										PART I DEATH WAS CAUSED BY:	
IMMEDIATE CAUSE (a) Multiple injuries complicated by fat embolism.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
8147											
DUE TO, OR AS A CONSEQUENCE OF											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY?										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										4:10 PM 7/17/80	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
road										21f. LOCATION (CITY OR TOWN COUNTY STATE)	
4711 Marlboro Pike, Prince Geore's, Md.											
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/> .											
ACTUAL SIGNATURE										TITLE (SPECIFY)	
Ann M. Dixon, M.D.										Assistant	
EXAMINER'S NAME (TYPE OR PRINT)										DATE SIGNED	
111 Penn St.										7-19-80	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE	
Burial										7/22/80	
23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (CITY OR TOWN COUNTY STATE)	
Washington Nat. Cem.										Suitland P.G. Co Md.	
24. FUNERAL DIRECTOR NAME										25a. DATE REC'D BY REGISTRAR	
Dudley's Funeral Home										JUL 21 1980	
ADDRESS										25b. SIGNATURE	
1125 Maryland Ave. N.E.											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 1 5 3 1 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>James Edward Updegraff Sr.</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>08-12-80</b>				2b. HOUR <b>2:37A M</b>
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>08 17 1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges County MD.</b>		
10. CITY OR TOWN OF DEATH <b>Beltsville, Md.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>10711 Montgomery Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Engineer</b>		
12b. KIND OF BUSINESS OR INDUSTRY <b>US Gov't</b>		13a. STREET ADDRESS <b>10711 Montgomery Road</b>		13b. INSIDE CITY LIMITS? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>		13c. CITY OR TOWN <b>Beltsville</b>		
13d. COUNTY <b>Pr. Georges'</b>		13e. STATE <b>Maryland</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>Clyde Updegraff</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret Lewis</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1918</b>		17. INFORMANT ADDRESS <b>James E. Updegraff (son) College Park, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> <b>410-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <b>Carcinoma of prostate</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES <input type="checkbox"/> NO <input type="checkbox"/></b>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (we) attended the deceased from <b>July 29, 1980</b> to <b>8-11-1980</b> , that (I) (we) saw the deceased alive on <b>8-11-1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>Azher Hussain</b>				DEGREE <b>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/></b>		22c. DATE SIGNED <b>8-12-80</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Azher Hussain, M.D.</b>				22e. ADDRESS <b>4917 Edgewood Road, College Park, Maryland 20740</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/15/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rolling Green Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Harrisburg Dauphin Pa.</b>		
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons, PA Hyattsville, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 15 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Concetta VANCHIERI</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8 5 80</b>			2b. HOUR <b>1 30 AM</b>				
3 SEX <b>Female</b>		4 RACE <b>white</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>12 8 03</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>ITALY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>PG County MD.</b>				
10 CITY OR TOWN OF DEATH <b>CLINTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CLINTON CONV. CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>PA.</b>					13b. COUNTY <b>TAYLOR</b>		13c. CITY OR TOWN <b>TAYLOR</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>UNKNOWN</b>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>167-44-4990</b>		17 INFORMANT ADDRESS <b>AL VANCHIERI, SON - SAME AS ABOVE</b>					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral vascular Accident</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Months</b>		
4/40 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUETO OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b>								Months		
DUETO OR AS A CONSEQUENCE OF (c) <b>Multiple infarcted Myocardium</b>								Months		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>7/26</b> , 19 <b>80</b> , to <b>8/5</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>8/4</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>R. M. M. M.</b>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8/5/80</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W. S. Z. M. M. M.</b>						22e. ADDRESS <b>4235 25th Ave and 2nd St</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>8-8-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Old Forge Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Old Forge LA. COUNTY PA.</b>			
24. FUNERAL DIRECTOR NAME <b>Homo</b>			24b. FUNERAL HOME <b>WILHELM FUN.</b>			24c. ADDRESS <b>4308 SUTLAND</b>			24d. CITY OR TOWN <b>AUG 11 1980</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 2 1 5 3 3	
FOR 1 - STATE REGISTRAR				CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Frank A. Vito</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>August 2, 1980</b>				2b. HOUR <b>7:10 P M</b>			
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 24, 1913</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>67</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash. D. C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George MD.</b>					
10 CITY OR TOWN OF DEATH <b>Clinton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Southern Maryland</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Plumber</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Plumbing</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>				13b. COUNTY <b>P. G.</b>		13c. CITY OR TOWN <b>Hillcrest</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2905 Oxon Park St.</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Dominic Vito</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ellen Fiorito</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>2nd.</b>		17. INFORMANT ADDRESS <b>Audrey M. Vito Wife 2905 Oxon Park St.</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>1629</b> IMMEDIATE CAUSE (a) <b>Carcinoma of Lung</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Obstructive Lung Dis</b> Conditions, if any, which gave rise to immediate cause (d), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>7/30 19 80</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>7/30</b> , 19 <b>80</b> , to <b>8/2</b> , 19 <b>80</b> , that (I) <del>met</del> last saw the deceased alive on <b>8/2</b> , 19 <b>80</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> <del>did not</del> <del>saw</del> the body after death.											
22b. SIGNATURE <b>R. A. McConaughy</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>8/3/80</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. A. McCONAUGHY MD</b>				22e. ADDRESS <b>5618 ST. BARNABUS RD. OXON HILL, MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>8-6-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Clinton Md.</b>			
24 FUNERAL DIRECTOR NAME <b>Robert E. Wilhelm Fun. Home Inc.</b>				ADDRESS <b>Suitland Md.</b>		25a. DATE REC'D BY REGISTRAR <b>AUG 11 1980</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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*[Faint, illegible handwriting and markings]*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 80 21534	
1. FOR STATE REGISTRAR										2a. DATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Joseph William Washington										2b. DATE OF DEATH ESTIMATED MONTH DAY YEAR 8 8 1980	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR June 30, 1942		6. AGE (IN YEARS LAST BIRTHDAY) 38 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 8 8 1980	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD	
10. CITY OR TOWN OF DEATH Cheverly				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Constr.	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.		13b. COUNTY P.G.		13c. CITY OR TOWN Seat Pleasant		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4907 Addison Rd. #202			
14. FATHER'S NAME FIRST MIDDLE LAST Jack Webster						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Washington					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 579-56-6493		17. INFORMANT ADDRESS Charles Briggs-1524 Jutewood St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot Wounds of Chest (handgun) 9650 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) } DUE TO, OR AS A CONSEQUENCE OF (c) }											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 8:45 P.M. 8 8 1980				21b. TIME OF INJURY HOUR MONTH DAY YEAR 8:45 P.M. 8 8 1980				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject shot			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) parking lot				21f. LOCATION CITY OR TOWN COUNTY STATE 4709 Addison Rd., Seat Pleasant, P.G., Md.			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Virginia L. Dolan				TITLE (SPECIFY) Assistant				DATE SIGNED 8/9/80			
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 8-13-80		23c. NAME OF CEMETERY OR CREMATORY Harmony Mem. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Highland Park, Md.			
24. FUNERAL DIRECTOR NAME H.S. WASHINGTON & SONS						ADDRESS 4925 BURNBOUGH AVE. N.E.		25a. DATE REC'D. BY REGISTRAR AUG 18 1980		25b. REGISTRAR'S SIGNATURE [Signature]	



June 30, 1945

U.S.A.

Laborer

4907 Addison St. 4902

Washington

Marie

Webster

Jack

570-56-6193 Charles Brien-1524 Lutescent St.

No

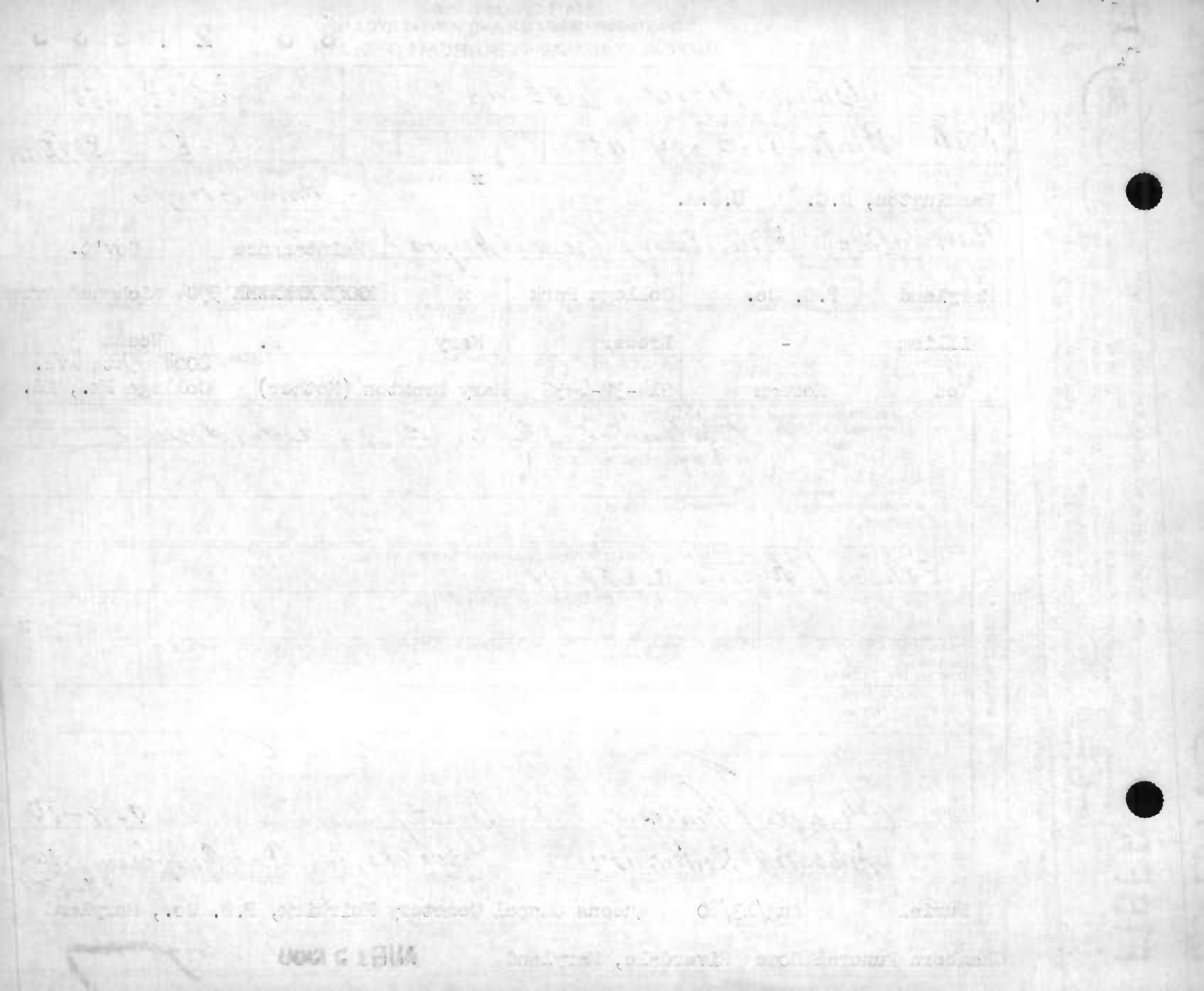
Serial 8-13-80 Harmony New. Com. Highland Park, Md.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, FURNISH A WRITTEN EXPLANATION TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 80 21535			
1- FOR STATE REGISTRAR						2a. DATE OF DEATH						2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)						2c. DATE OF DEATH ESTIMATED						2d. HOUR			
James Alfred WEEMS						8-8-80						1980			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Male		Black		11-3-34		45 YRS						8-8-80		1980	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
Washington, D.C.				U.S.A.								Baltimore City			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly (DC)				Prince Georges General Hospital				Maintenance				Gov't.			
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland				P.G. Co.		College Park		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5504 Richmond Avenue					
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME									
William Brewer						Mary E. Weems									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
Yes				Korean				214-32-8432				Mary Braxton (Mother) College Pk., Md.			
18. CAUSE OF DEATH (Enter only one cause per line, (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a)															
4292. <i>Arteriosclerotic cardiovascular disease</i>															
DUE TO, OR AS A CONSEQUENCE OF															
(b)															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
<i>Ethanol Depoite arrthrosis</i>															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?			
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
				HOUR A.M. MONTH DAY YEAR											
				P.M. 19											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION							
								CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED							
<i>Augusto Rodriguez</i>				M.D. <i>Deputy</i>				8-8-80							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS											
<i>Augusto P. Rodriguez</i>				5504 Richmond Avenue, Prince Georges, Md											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION					
Burial				Aug/13/80		Queens Chapel Cemetery				Muirkirk, P.G. Co., Maryland					
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
NAME ADDRESS						AUG 15 1980		<i>[Signature]</i>							
Chambers Funeral Home Riverdale, Maryland															





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8021536									
1. FOR STATE REGISTRAR										REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)					FIRST MIDDLE LAST					2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR					
MARGARET V. WESTBROOK										08-18-80				1:40PM					
3 SEX		4 RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS							
F		N		MONTH DAY YEAR Dec 17 1907			52 YRS.			MONTHS DAYS		HOURS MIN.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH											
N.C.		U.S.A.						PRINCE GEORGE'S MD.											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
CHEVERLY				PRINCE GEORGE'S GENERAL HOSPITAL				Minister			Church								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS	
										Md		P. G.		Landover		20785-1127 Capital View Drive			
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME														
FIRST MIDDLE LAST					FIRST MIDDLE LAST														
William Fulton					Unknown														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS									
No					None					226-01-4829 Ruby Broadway 7104 E. Lombard st Landover Md									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 1: DEATH WAS CAUSED BY																			
IMMEDIATE CAUSE (a) PERITONITIS																			
DUE TO, OR AS A CONSEQUENCE OF (b) RUPTURED DIVERTICULITIS																			
DUE TO, OR AS A CONSEQUENCE OF (c)																			
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):																			
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
					P.M.														
21d. INJURY OCCURRED					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION									
WHILE <input type="checkbox"/> AT WORK HOT WHILE <input type="checkbox"/> AT WORK										CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 8/08 19 80 to 8/18 19 80 that (I) (we) last saw the deceased alive on 8/18 19 80 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) (did) (do not) view the body after death.																			
22b. SIGNATURE										DEGREE		22c. DATE SIGNED							
Attending Physician										MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		8-22-80							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS														
Ronald P. Hairston MD.					6910 Columbia Plc Rd Landover														
23a. BURIAL (SPECIFY)					23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION									
(SPECIFY)					8-23-80		Harmony Cem.			CITY OR TOWN COUNTY STATE									
										Highland Park MD									
24. FUNERAL DIRECTOR					25a. DATE REC'D. BY REGISTRAR					25b. REGISTRAR'S SIGNATURE									
NAME ADDRESS					AUG 27 1980					Pitney McCready									
115 Washington 4925 NE																			

U. S. DEPARTMENT OF THE ARMY

OFFICE OF THE ADJUTANT GENERAL

WASHINGTON, D. C.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR THE DIVISION OF VITAL RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 21537			
1- STATE REGISTRAR												2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Joseph J. Wetherald</b>												ESTIMATED <input checked="" type="checkbox"/> 5-4 1980		2b. HOUR 23	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4-23-1894</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD <b>August 4, 1980</b>		7d. HOUR			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>P.G.</b>			
10. CITY OR TOWN OF DEATH <b>Cheverly</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Pr. Geo. Gen. Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Agricultural Aid</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Dept. of Agr.</b>			
13a. STATE <b>Md.</b>				13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>College Park</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>8411 58th. Ave.</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>John E. Wetherald</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Gertrude Haviland</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>215-38-4922</b>		17. INFORMANT <b>Thomas R. Wetherald</b>				ADDRESS <b>Address Same as No# 13e.</b>					
18. CAUSE OF DEATH (Enter only one cause per line) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Markingant Lymphoma</b> 2028 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b>				TITLE (SPECIFY) <b>Deputy</b>				MEDICAL EXAMINER				DATE SIGNED <b>8-5-80</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Augusto P. Rodriguez, M.D.</b>				ADDRESS <b>5009 Rayburn Ct. Camp Spring, Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>8-8-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland P.G. Md.</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>F. Gasch's Sons F.H. P.A. Hyattsville, Md.</b>								25a. DATE REC'D. BY REGISTRAR <b>AUG 8 1980</b>		25b. REGISTRAR'S SIGNATURE <b>History/History</b>					



Name		Address		Occupation	
Mr. J. H. Smith	123 Main St.	Chicago, Ill.	1900	Teacher	1900
Mr. J. H. Smith	123 Main St.	Chicago, Ill.	1900	Teacher	1900
Mr. J. H. Smith	123 Main St.	Chicago, Ill.	1900	Teacher	1900
Mr. J. H. Smith	123 Main St.	Chicago, Ill.	1900	Teacher	1900
Mr. J. H. Smith	123 Main St.	Chicago, Ill.	1900	Teacher	1900
Mr. J. H. Smith	123 Main St.	Chicago, Ill.	1900	Teacher	1900
Mr. J. H. Smith	123 Main St.	Chicago, Ill.	1900	Teacher	1900
Mr. J. H. Smith	123 Main St.	Chicago, Ill.	1900	Teacher	1900
Mr. J. H. Smith	123 Main St.	Chicago, Ill.	1900	Teacher	1900
Mr. J. H. Smith	123 Main St.	Chicago, Ill.	1900	Teacher	1900

Handwritten notes and signatures at the bottom of the page, including a large signature that appears to read "J. H. Smith".

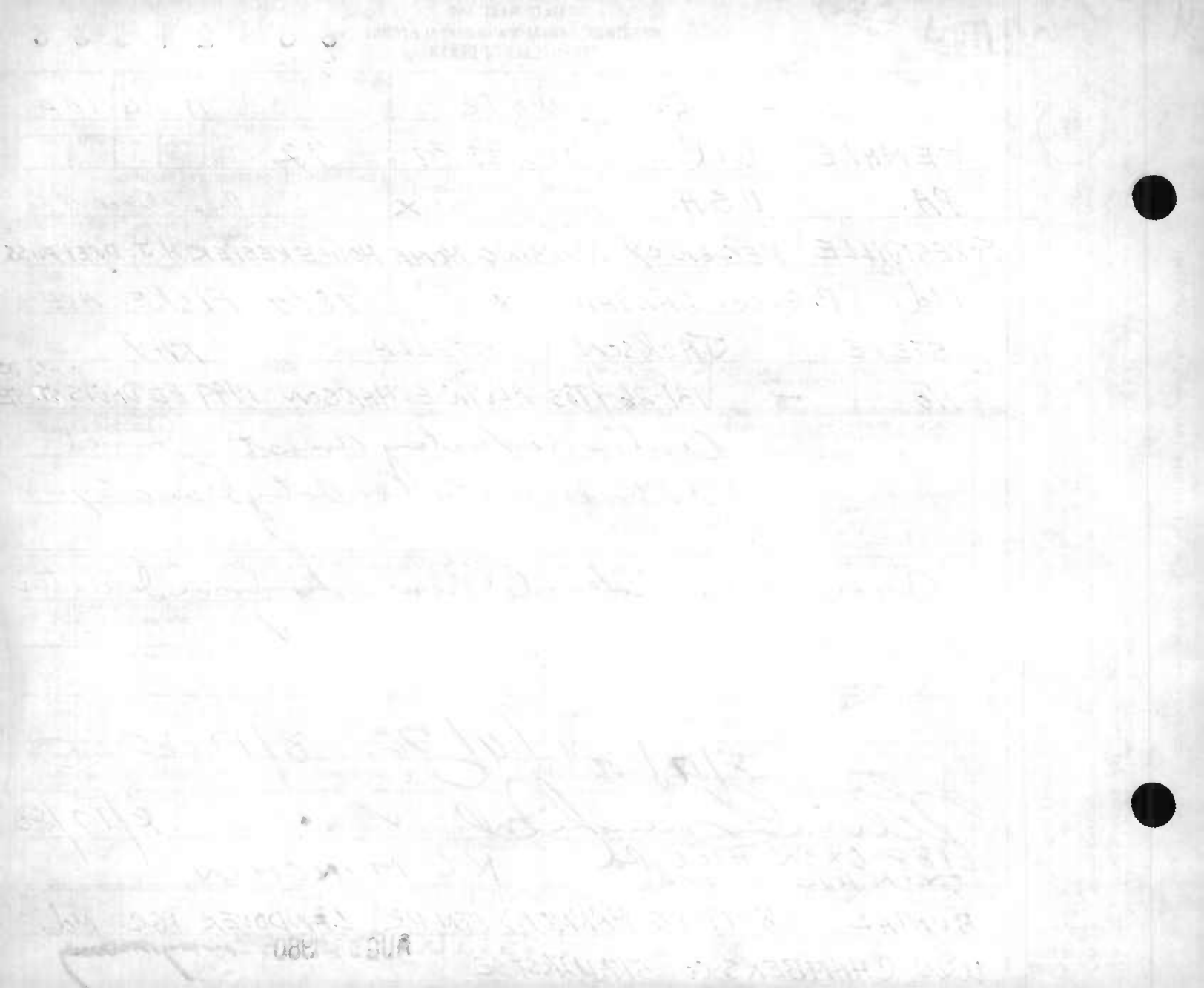
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8021538		
1. FOR STATE REGISTRAR			REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH DAY YEAR		2b. HOUR	
ELLA D. White						8 17 80			10 P.M.			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7a. UNDER 1 YEAR		7b. UNDER 24 HRS		
FEMALE		BLK		11 27 07		72 YRS.		MONTHS DAYS		HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH						
PA.		U.S.A.				Prince George MD.						
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
FORESTVILLE		REGENCY NURSING HOME				HOUSEKEEPER		H. J. DREIFUSS				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md.			P.G. CO.		LANHAM		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7804 FISKE AVE.			
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
STEVE JACKSON			STELLA RAY									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS					
NO			131-26-9783		ALVIN E. HANSON		1499 F.B. DAVIS ST. SE. WASH. DC.					
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.)										APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH		
PART 1: DEATH WAS CAUSED BY:										Immediacy		
IMMEDIATE CAUSE 18a: Cardio respiratory Arrest										Immediacy		
4149 DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause 18a, stating the underlying cause last												
(b) Anteriorly Cor. Artery Disease Syn.												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
Pneumonia, Senile Brain Syndrome Diabetes												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
			HOUR A.M. MONTH DAY YEAR									
			P.M. 19									
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION		CITY OR TOWN COUNTY STATE				
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>						STREET						
22a. I certify that (i) (this hospital) attended the deceased from 8/12/80 to 8/12/80 that (ii) (we) last saw the deceased alive on 8/12/80 and that (iii) (our) opinion death occurred on the date and hour and from the causes stated												
22b. SIGNATURE												
22c. PHYSICIAN'S NAME (TYPE OR PRINT)												
6188 OXON HILL RD OXON HILL MD												
22d. ADDRESS												
K.C. MINCHIN												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
BURIAL			8-19-80		HARMONY MEM. PK		LANDOVER PGC. Md.					
24 FUNERAL DIRECTOR			NAME		ADDRESS		25a. REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
W.W. CHAMBERS CO.			517-11TH ST SE.				AUG 21 1980					





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS ARE NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M/7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

0 21539

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Sarah</i>			MIDDLE <i>WHITE</i>			LAST <i>WHITE</i>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <i>8</i> DAY <i>24</i> YEAR <i>80</i>			2b. HOUR <i>10</i>					
3. SEX <i>Female</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH <i>6</i> DAY <i>10</i> YEAR <i>01</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>79</i> YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH <i>8</i> DAY <i>24</i> YEAR <i>80</i>		2d. HOUR <i>10</i>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>VA.</i>				7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince George</i>					
10. CITY OR TOWN OF DEATH <i>(Medley (Dor))</i>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Prince Georges General Hospital</i>								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOUSEWIFE</i>				12b. KIND OF BUSINESS OR INDUSTRY <i>HOME</i>	
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <i>MD.</i>				13b. COUNTY <i>P.G.</i>				13c. CITY OR TOWN <i>CAP. HCTS.</i>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>5113 DOPPLER ST.</i>			
14. FATHER'S NAME FIRST <i>UNKNOWN</i> MIDDLE LAST								15. MOTHER'S MAIDEN NAME FIRST <i>HENRIETTA</i> MIDDLE <i>HARRIS</i> LAST									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO. <i>577-09-1738</i>				17. INFORMANT ADDRESS <i>EVELYN DOUGHERTY - SAME AS #13 ABOVE</i>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>Pulmonary Tuberculosis</i>																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE <i>August P. Rodriguez</i>				M.D. <i>Deputy</i>				MEDICAL EXAMINER				DATE SIGNED <i>8/24/80</i>					
EXAMINER'S NAME (TYPE OR PRINT) <i>August P. Rodriguez</i>				ADDRESS <i>3609 Rappahannock Court, Chevy Chase, Md. 20815</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE <i>8-29-80</i>				23c. NAME OF CEMETERY OR CREMATORY <i>LINCOLN MEM. CEM.</i>				23d. LOCATION CITY OR TOWN <i>SUITLAND</i> COUNTY <i>P.G.</i> STATE <i>MD.</i>					
24. FUNERAL DIRECTOR NAME <i>H.S. WASHINGTON &amp; SONS</i> ADDRESS <i>4425 BURROUGHS AVE. N.E.</i>								25a. DATE REC'D. BY REGISTRAR <i>AUG 29 1980</i>				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					







2. Growth of *Salmonella* in the presence of *Staphylococcus aureus* and *Escherichia coli*.

• D. H. Thompson •

• 2017 •

1945

1900

Released to PMD by Medical Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				80 21541 REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MAGDALENA MARIE WILHELM				2b. HOUR 7:45A M			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 1-8-1890		6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 90 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10 CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Bldg. Supervisor		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Charles		13c. CITY OR TOWN Newburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST (Unknown) Heuser		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (Unknown)		13e. STREET ADDRESS 123 - Woodland Pt. Rd.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO -		17 INFORMANT ADDRESS Lois C. Wilhelm Same as above			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4149 Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral Ischemia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Cerebral Ischemia							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 90, to 8-25-80, that (I) (we) lost saw the deceased alive on 8-25-80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Ohanne Sahakian				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/25/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ohanne Sahakian, M.D.				22e. ADDRESS 6001 Landover Road, Cheverly, Md. 20785			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-28-80		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md.	
24 FUNERAL DIRECTOR NAME Nalley's F.H. Inc.				ADDRESS Mt. Rainier, Md.		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S NAME SEP 2 1980	



1 2 3 4 5

1st. 2nd. 3rd. 4th. 5th.

1st. 2nd. 3rd. 4th. 5th.

(Signature)

1st. 2nd. 3rd. 4th. 5th.

SEP 1980

**DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Ruth</i>		MIDDLE <i>Amy</i>		LAST <i>WILKERSON</i>		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <i>8-1 19 80</i>		2b. HOUR <i>8:35</i>	
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>12-26-16</i>		6. AGE (IN YEARS) LAST BIRTHDAY <i>63</i> YRS.		IF UNDER 1 YR. MONTHS DAYS <i>63</i>		IF UNDER 24 HRS. HOURS MIN <i>63</i>		7c. DATE PRONOUNCED DEAD <i>8-1 19 80</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i> MD.					
10. CITY OR TOWN OF DEATH <i>Clinton (DOK)</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Southern Maryland Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Receptionist</i>		12b. KIND OF BUSINESS <i>Credit Union</i>			
13a. STATE <i>Maryland</i>						13b. COUNTY <i>P.G.</i>		13c. CITY OR TOWN <i>Brandywine</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Walter Philip Nair</i>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Clarie West</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>579-09-1010</i>		17. INFORMANT ADDRESS <i>M. Mark Wilkerson same as 13</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Diabetic arteriosclerotic Cardiac Vascular Disease</i> <i>2507</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>				TITLE (SPECIFY) <i>Deputy</i>				DATE SIGNED <i>8-1-80</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez M.D.</i>				ADDRESS <i>5009 Rayburn Ct., Camp Springs, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>8-4-80</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Trinity Mem. Gardens</i>				23d. LOCATION CITY OR TOWN COUNTY STATE <i>Waldorf, Charles, Md.</i>			
24. FUNERAL DIRECTOR NAME ADDRESS <i>Hunt Funeral Home, Waldorf, Md.</i>				25a. DATE REC'D. BY REGISTRAR <i>AUG 7 1980</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

Handwritten notes and stamps, including "D. H. H." and "U. S. DEPARTMENT OF JUSTICE".

Handwritten notes and stamps, including "JULY 1940" and "U. S. DEPARTMENT OF JUSTICE".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8021543 REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH 08-15-80			
1. DECEASED NAME (TYPE OR PRINT) FIRST ANNA MIDDLE T. LAST WILLIAMS				2b. HOUR 6:04AM			
3 SEX Female		4 RACE White		5 DATE OF BIRTH Jan. 17, 1904		6 AGE (IN YEARS LAST BIRTHDAY) 76	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.	
10 CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES GENERAL HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY Housewife	
13a. STATE Kentucky				13b. CITY OR TOWN Sussex		13c. STREET ADDRESS 7538 Sussex Drive	
14 FATHER'S NAME Nicholas Rave				15. MOTHER'S MAIDEN NAME Anna M. Schill			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. None		17 INFORMANT ADDRESS 9517 Sherwood Dr Upper Marlboro			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma				Maryland 20870			
1991				APPROXIMATE INTERVAL AND DEATH 1 month			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				DUE TO, OR AS A CONSEQUENCE OF (b)			
				DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7-28, 1980, to 8-15, 1980, that (we) lost saw the deceased alive on 8-15, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.							
22b. SIGNATURE Barry Epstein MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/15/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY EPSTEIN MD				22e. ADDRESS 6201 GREENBELT RD COLLEGE PK MD 20704			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/20/80		23c. NAME OF CEMETERY OR CREMATORY Lake Side Mem. Gardens Eustis Fla.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24 FUNERAL DIRECTOR NAME Lee Funeral Home Inc.				25a. DATE REC'D AUG 25 1980		25b. RECEIVED BY	
6683 Old Alexander Ferry Road Clinton, Maryland							



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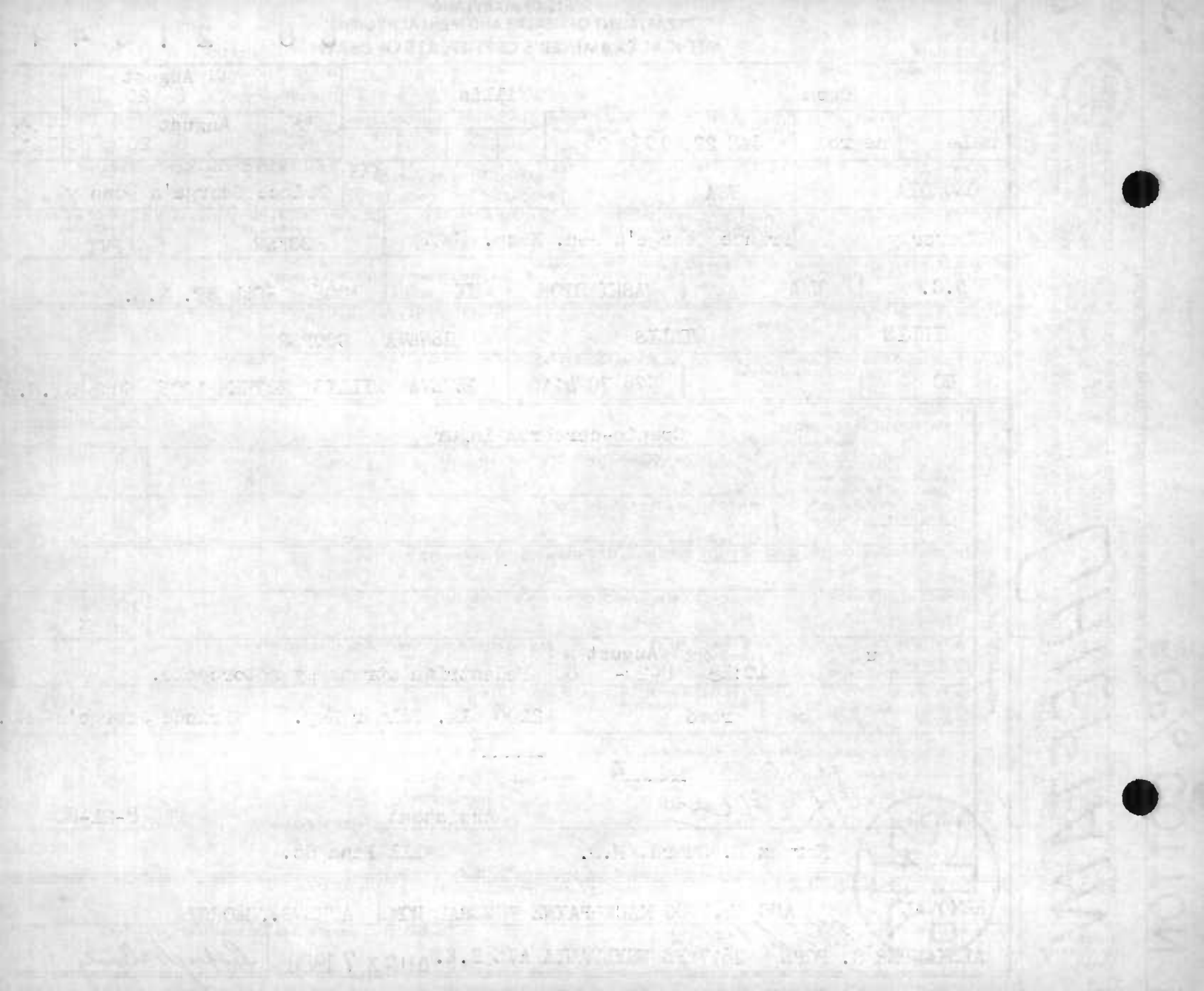
DHMH - 17  
(VR A15 ME (5))  
15M 7/77

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 80 21544	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Owen Willis						2a. DATE KNOWN OF DEATH		2b. HOUR			
3. SEX male 4. RACE negro 5. DATE OF BIRTH JAN 22, 1952 6. AGE (IN YEARS) 28						2c. DATE PRONOUNCED DEAD August 8 20 19 80		2d. HOUR 11:32			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GEORGIA			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD		
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's Gen. Hosp. (DOA)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ROOFER			12b. KIND OF BUSINESS OR INDUSTRY PVT		
13a. STATE D.C.			13b. COUNTY N/A			13c. CITY OR TOWN WASHINGTON			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME WILLIE			15. MOTHER'S MAIDEN NAME GENEVA COOPER			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 578 70 4110		
17. INFORMANT			ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cranio-cerebral injury 8147 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY 10:13 A.M. 8-20-19 80			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Pedestrian struck by motorcycle.					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road			21f. LOCATION 2200 blk. Palmer Hwy. Prince George's Md					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			TITLE (SPECIFY) Assistant			DATE SIGNED 8-21-80					
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.			ADDRESS 111 Penn St.								
23a. BURIAL, CREMATION, REMOVAL REMOVAL			23b. DATE AUG 21, 1980			23c. NAME OF CEMETERY OR CREMATORY MACK & PAYNE FUNERAL HOME			23d. LOCATION CITY OR TOWN ATHENS, GEORGIA		
24. FUNERAL DIRECTOR NAME ALEXANDER S. POPE			25a. DATE REC'D. BY REGISTRAR AUG 27 1980			25b. REGISTRAR'S SIGNATURE					

DHMH - 17  
(VR A15 ME (5))  
15M 7/77





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					8 0 2 1 5 4 5 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lucy C. Wood					2a. DATE OF DEATH MONTH DAY YEAR August 6 1980			2b. HOUR 10:26pM	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 19, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS		IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince-Georges MD.			
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4200 Loch Raven Blvd.	
14. FATHER'S NAME FIRST MIDDLE LAST John Luther Ford					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Jane Warner				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					16b. SOCIAL SECURITY NO. 220-50-0936		17. INFORMANT ADDRESS John D. Ford, 9711 Holmhurst Rd. Beth.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> 496- DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Chronic obstructive pulmonary disease</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>Chronic cirrhosis of liver</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 4 year 6 years	
								PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)	
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 19</u> , 19 <u>74</u> , to <u>August 6</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>Aug 6</u> , 19 <u>80</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE Thomas F. Collins					DEGREE MD			22c. DATE SIGNED 8-7-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS F. COLLINS					22e. ADDRESS 2600 Queen Chapel Rd				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug 11, 1980		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD		23e. REC'D. BY REGISTRAR AUG 11 1980	
24. FUNERAL DIRECTOR NAME Takoma Funeral Home, 2811 Calver St.					25. REGISTRAR'S SIGNATURE [Signature]				

MEDICAL CERTIFICATION

John D. Ford, 9711 Holmhurst Rd. Beth.

1982-1983

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR										80 21546	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHNNIE WOODLEY SR.					2a. DATE OF DEATH MONTH DAY YEAR 08-21-80			2b. HOUR 4:20 PM			
3. SEX MALE		4. RACE BLK		5. DATE OF BIRTH MONTH DAY YEAR 10-11-92		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. CAR		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.					
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CONSTRUCTION		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MD.		13b. COUNTY PRINCE GEORGE		13c. CITY OR TOWN LARGO		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1002 TREBING LA.			
14. FATHER'S NAME FIRST MIDDLE LAST BEVERLY WOODLEY					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. INVT 054-09-7984		17. INFORMANT ADDRESS LARGO MD. JOHNNIE WOODLEY JR. 1002 TREBING LA.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SEPTIC SHOCK 185- DUE TO, OR AS A CONSEQUENCE OF (b) GANGRENE OF NON VIABLE (R) lower limb DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIAL OCCLUSION METASTATIC CARCINOMA PROSTATE PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). SEVERE AZOTHEMIA										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 08-11-80, 1980, to 8-21, 1980, that (I) (we) lost saw the deceased alive on 8/21/80, 1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death.										22c. DATE SIGNED 4-25 PM	
22b. SIGNATURE Prospero Zavallos MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED August 21, 80				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PROSPERO ZEVALLOS M.D.				22e. ADDRESS 222 LASTNER LN. GREENBELT, MD							
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL		23b. DATE 8-28-80		23c. NAME OF CEMETERY OR CREMATORY ROSEDALE CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE LINDEN N.Y.					
24. FUNERAL DIRECTOR NAME BARNES & MATTHEWS, INC.				ADDRESS 3619-14th St. NW		25a. DATE REC'D. BY REGISTRAR 0 AUG 28 1980		25b. REGISTRAR SIGNATURE [Signature]			



038 8 5011 0

MEDICAL EXAMINER NOTIFIED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

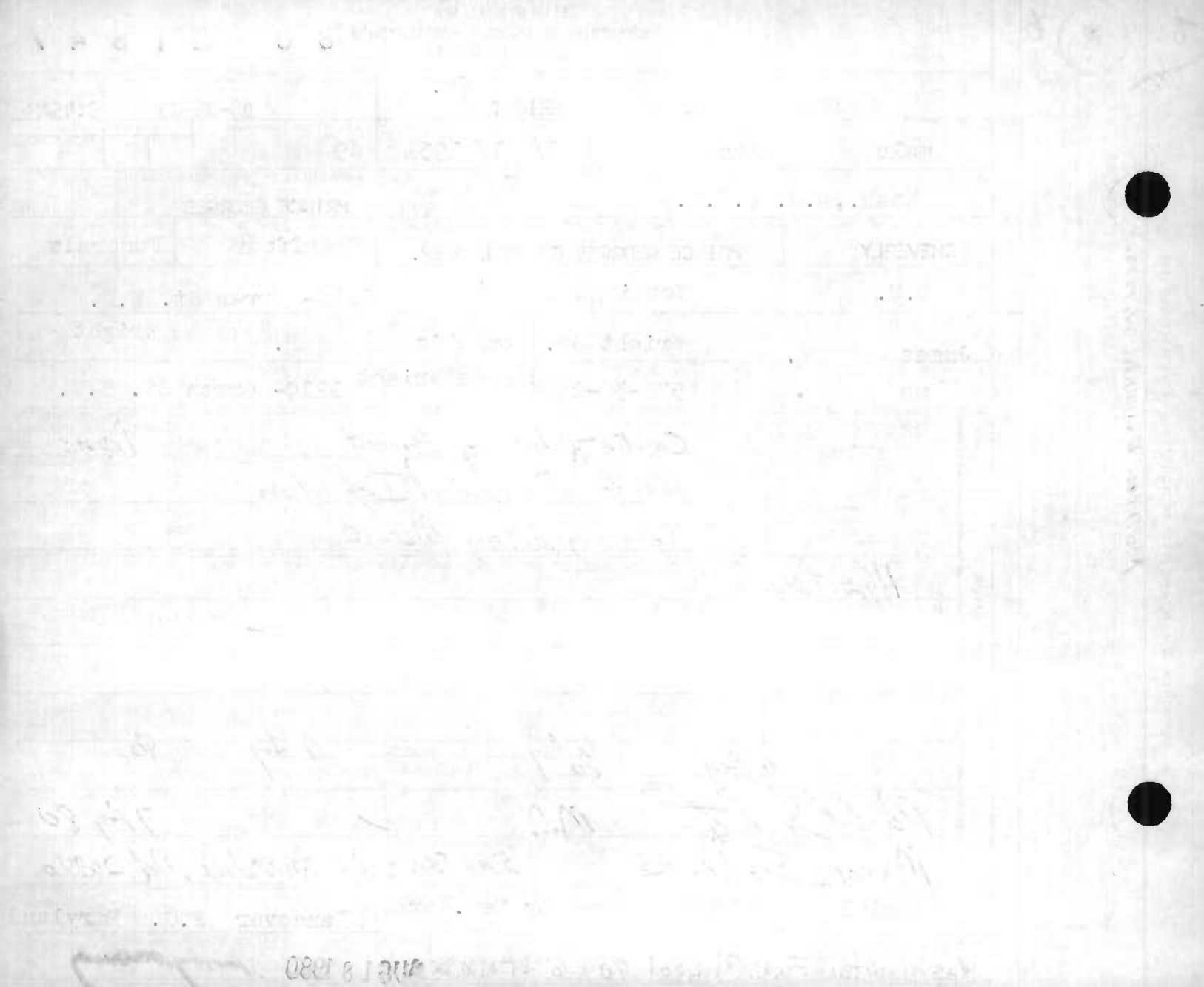
REG. NO.

2 1 5 4 7

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JAMES W. WRIGHT Jr.			2a. DATE OF DEATH MONTH DAY YEAR 08-06-80		2b. HOUR 8:45AM
3 SEX male	4 RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 2/ 1/ 1931	6 AGE (IN YEARS LAST BIRTHDAY) 49		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.		
10 CITY OR TOWN OF DEATH CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES GENERAL HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chauffeur		12b. KIND OF BUSINESS OR INDUSTRY Funerals
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE D.C. 13b. COUNTY Prince Georges 13c. CITY OR TOWN Washington			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 1210- Orren St. N.E.	
14. FATHER'S NAME FIRST MIDDLE LAST James W. Wright Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE Ophelia P. Wright			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 579-36-2405	17 INFORMANT ADDRESS Agnes Wright 1210- Orren St. N.E.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-pulmonary Arrest</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Artery Disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 hrs					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Hypertension</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>6 Aug</u> 19 <u>80</u> to <u>6 Aug</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>6 Aug</u> 19 <u>80</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Michael Schaefer</u>		DEGREE M.D.		22c. DATE SIGNED 7 Aug 80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL SCHAEFER		22e. ADDRESS 5711 SARVIS Ave Riverdale, Md 20840			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8/12/80	23c. NAME OF CEMETERY OR CREMATORY Harmony Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Landover P.G. Maryland	
24. FUNERAL DIRECTOR NAME Washington Fun. Chapel		ADDRESS 909-6th St. N.W. D.C.		25a. DATE REC'D. BY REGISTRAR AUG 18 1980	25b. REGISTRAR'S SIGNATURE <u>Anthony Schaefer</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8021548  
REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) LEE Roy WRIGHT			2a DATE OF DEATH MONTH DAY YEAR 8 20 80			2b HOUR 8:45 AM					
3 SEX male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Aug 27 1890		6 AGE (IN YEARS LAST BIRTHDAY) 89 YRS		7a IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7c CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.					
10 CITY OR TOWN OF DEATH Forestville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Regency Nursing Home				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinest		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md.			13b COUNTY PG		13c CITY OR TOWN Camp Springs		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 4809 Sharon Road		
14 FATHER'S NAME FIRST MIDDLE LAST Robert Wright			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Belle Ferguson			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b SOCIAL SECURITY NO 234-18-8481	
17 INFORMANT Same as Above			17 ADDRESS Dorothy W. Lindbeck, Daughter								
18 CAUSE OF DEATH (Enter only one cause per line for 10a, 10b, and 10c) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 185- Cardio Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Dehydration DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma Prostate Metastasis 2+ yrs APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) COPD & Diabetes Mellitus Severe Deabiti											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from 8/20/80 to 8/20/80, that (I) (we) last saw the deceased alive on 8/20/80, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)											
22b SIGNATURE Kelvin Minchin M.D.						DEGREE M.D.			22c DATE SIGNED 8/20/80		
22d PHYSICIAN'S NAME (TYPE OR PRINT) Kelvin Minchin, M.D.						22e ADDRESS 6188 Oxon Hill Rd., Oxon Hill, Md.					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 8-22-80			23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.			23d LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G., Maryland		
24 FUNERAL DIRECTOR NAME Robt E Wilhelm			ADDRESS 4308 Suitland Rd., Suitland, Md.			25. DATE REC'D BY REGISTRY AUG 26 1980					

BP



1944 12 23

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 1 5 4 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Lillie Suggs</b>		LAST <b>WRIGHT</b>		2a. DATE OF DEATH MONTH YEAR <b>August 25, 1980</b>		2b. HOUR <b>2:20 P</b>	
3 SEX <b>Female</b>		4 RACE <b>Negro</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>February 12, 1912</b>		6 AGE (IN YEARS LAST BIRTHDAY) YRS. <b>68</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County, MD</b>	
10 CITY OR TOWN OF DEATH <b>Glenn Dale</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Glenn Dale Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>House Worker</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>PG</b>		13c. CITY OR TOWN <b>Glenn Dale</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>George Suggs</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Cora Swinson</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO <b>Unavailable</b>	
17 INFORMANT <b>Horace Suggs, Brother,</b>		ADDRESS <b>2727 Shipley Terr., S.E. Apt 6</b>		CITY <b>Washington, D.C.</b>			
11 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolism</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>Old cerebrovascular accident with right hemiplegia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>/</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: <b>Hypertension; chronic brain syndrome</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <del>X</del> (this hospital) attended the deceased from <b>May 6, 1977</b> , to <b>August 25, 1980</b> , that <del>X</del> (we) last saw the deceased alive on <b>August 25, 1980</b> , and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>(I)</del> (we) did not view the body after death.							
22b. SIGNATURE <b>James W. Wills M.D.</b>				DEGREE <b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input checked="" type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/>		22c. DATE SIGNED <b>Aug. 25, 1980</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>James W. Wills, M.D.</b>				22e. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Maryland 20769</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8-30-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Snow Hill Church Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Snow Hill N.C.</b>	
24 FUNERAL DIRECTOR NAME <b>Bacon Funeral Home,</b>		ADDRESS <b>Washington, D.C.</b>		25a. DATE REC'D BY REGISTRAR <b>AUG 28 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony M. Brady</b>	

re To sh w in

DHMH-16 25M  
(VRA 15, 4) 1/79



**MEDICAL CERTIFICATION**

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	REG. NO.		2a. DATE KNOWN OF DEATH		MONTH	DAY	YEAR	7b. HOUR			
Rebecca K Wright							X		8	6	1980				
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH	DAY	YEAR	7d. HOUR	
female	white	April 29 1949		31 YRS.					8 6 1980					7:17A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH								
Washington, DC.		U.S.A.			WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		Prince George County MD								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY								
Laurel		Greater Laurel/Beltsville Hosp.			Housewife		Home								
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS							
Maryland		Prince Georges		Adelphi				7300 18th Ave.							
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Dan Kelly Monroe				Mary Josephine Kriss											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) IF YES, GIVE WAR OR DATES				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No N/A				214-52-5458		James Monroe		15127 Belmia Drive Laurel, Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> <u>9/102</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR P.M. MONTH DAY YEAR 6:00 AM 8/6/ 1980		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) swimming in pool											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.). Community swimming pool		21f. LOCATION Hammond Village Community swimming pool Fulton Howard Co., Md.											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <u>H.R. Guard</u>		TITLE (SPECIFY) Assistant		MEDICAL EXAMINER		DATE SIGNED 8/7/80									
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS													
Hormez R. Guard, M.D.		111 Penn Street, Balto. MD 21201													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE									
Burial		Aug. 11 1980		Md. Natl. Memorial park		Laurel Maryland									
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Beall F.H.		9013 Annapolis Rd. Lanham, Md.		AUG 15 1980		<u>[Signature]</u>									



WASHINGTON, D. C. 20250

OFFICE OF THE SECRETARY OF AGRICULTURE

WASHINGTON, D. C. 20250

UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C. 20250

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UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C. 20250

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1. STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 0 1 2 1 5 5 1 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WILLIAM C. WYLAND</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Aug. 29, 1980</b>		2b. HOUR <b>7:50 PM</b>
3 SEX <b>Male</b>	4 RACE <b>2</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>08/01/04</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna.</b>	7b CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges County MD.</b>	
10 CITY OR TOWN OF DEATH <b>Clinton</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SOUTHERN MARYLAND HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Penna R.R.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>
13a. STATE <b>Penna.</b>	13b. COUNTY <b>Blair</b>	13c. CITY OR TOWN <b>Altoona</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>304 Lexington Ave.</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>William Wyland</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Unk</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>***</b>		17 INFORMANT ADDRESS <b>Mrs. Janet Poust, Clinton, Maryland</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>EMPHYSEMA / RESPIRATORY FAILURE YEARS</b> <b>492-</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: <b>HYPOTENSION BRADY CARDIA</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <b>8/29</b> 19 <b>80</b> to <b>8/29</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>8/29</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>P. Wisotsky</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>8/30/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>P. WISOTSKY MD.</b>		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/2/1980</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Ridge Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Altoona, Blair Penna</b>
24 FUNERAL DIRECTOR NAME <b>Lee Funeral Home, Clinton, Maryland</b>		25. PREPARED BY (NAME OF REGISTRAR'S SIGNATURE) <b>SEP 4 1980</b>			



7:50 PM

*[Faint, illegible markings]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8021552 REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN THOMAS YOUNG				2a. DATE OF DEATH MONTH DAY YEAR AUGUST 8, 1980			
3 SEX MALE				2b. HOUR 4:08 PM			
4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR April 19, 1908		6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MISSOURI		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10 CITY OR TOWN OF DEATH Andrews AFB		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcolm Grow USAF Medical Center		9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) USAF				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland				13b. COUNTY Prince Geo.		13c. CITY OR TOWN Temple Hills	
14 FATHER'S NAME FIRST MIDDLE LAST Wilford Young				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Mae Draper			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO WWII-Kor. 577-52-6581		17 INFORMANT ADDRESS Eleanor A. Young 4116 Holly Tree Rd Temple Hills, Md			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>0389</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>21 July</u> 19 <u>80</u> , to <u>8 August</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>8 August</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Charles A. Gaputis</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>8 AUG 80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles A. Gaputis, Capt, USAF, MC MG USAF MED CEN Andrews AFB, MD 20331				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12 Aug 1980		23c. NAME OF CEMETERY OR CREMATORY Arlington National Arlington		23d. LOCATION CITY OR TOWN COUNTY STATE Va.	
24 FUNERAL DIRECTOR'S NAME Robert E. Wilhelm Funeral Home Inc				24b. ADDRESS Suitland, Md		25a. DATE REC'D. BY REGISTRAR AUG 15 1980	
				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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FOR 1 - STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 1 5 5 3 REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ERNEST M. ZIEGLER</b>				2a DATE OF DEATH MONTH DAY YEAR <b>08 14 80</b>				2b HOUR <b>3:20A.M.</b>			
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec 5 1914</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		IF UNDER 24 HRS HOURS MIN. <b>0 0</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b> MD.					
10 CITY OR TOWN OF DEATH <b>Clinton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Southern Maryland Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Self-Employed</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Pizza - Ziggy</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE 13b COUNTY 13c CITY OR TOWN <b>Md. PG Oxon Hill</b>				13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>501 Wilson Bridge Dr. A-2</b>					
14 FATHER'S NAME FIRST MIDDLE LAST <b>Ernest Theodore Ziegler</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna May Lang</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>W.W.II 579-07-3858</b>		17 INFORMANT ADDRESS <b>Richard T. Ziegler, Brother 1220 19th St. Wash., D. C.</b>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>At lobar pneumonia &amp; pulmonary abscesses</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Marked emphysema COPD</b> ← <b>Years</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cor pulmonale - cardiorespiratory failure</b> <b>2 months</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1-2 weeks</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <b>8-14</b> 19 <b>80</b> to <b>8-14</b> 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>8-14</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <b>William C. Silberman</b>				DEGREE				22c DATE SIGNED <b>14 Aug 80</b>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>William C. Silberman</b>				22e ADDRESS <b>7503 Suitland Rd. Clinton Md.</b>							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b DATE <b>8-18-80</b>		23c NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, PG, Maryland</b>			
24 FUNERAL DIRECTOR NAME <b>Robt E Wilhelm</b>				ADDRESS <b>4308 Suitland Rd., Suitland, Md.</b>				25a DATE REC'D. BY REGISTRAR <b>AUG 19 1980</b>		25b REGISTRAR'S SIGNATURE <b>Dorothy McCreedy</b>	



5 4 3 2 1 0